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Description of document: Department of Health and Human Services (HHS) FY2022 Capital Plan (for Real Estate), 2021

Requested date: 18-January-2021

Release date: 03-April -2023

Posted date: 22-January-2024

Source of document: FOIA Request  
Department of Health and Human Services (HHS) Office of the Secretary (OS)  
Freedom of Information Act Office  
Hubert H. Humphrey Building, Room 729H  
200 Independence Avenue, SW  
Washington, D.C. 20201  
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Assistant Secretary for Public Affairs  
Washington, D.C. 20201

**Case No. 2021-00769-FOIA-PHS**

**April 3, 2023**

*Sent via email:*

This letter is the final response to your January 18, 2021, Freedom of Information Act (FOIA) request. Specifically, you requested the following records:

*"a copy of the HHS Capital Plan as required and described in OMB Memorandum M-20-03 issued November 6, 2019 and M-20-03 Implementation Guidance issued July 2, 2020."*

The Office of Real Estate, Logistics, and Operations (RELO) conducted a search for records responsive to your request and located 61 pages of responsive record. After a careful review of the information, I have determined to release it to you in its entirety.

If you are not satisfied with any aspect of the processing and handling of this request, you have the right to seek dispute resolution services from:

HHS FOIA/PA Public Liaison  
FOI/Privacy Acts Division  
Assistant Secretary for Public Affairs (ASPA)  
Office of the Secretary (OS)  
U.S. Department of Health and Human Services (HHS)

Telephone: (202) 690-7453  
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E-mail: [HHS\\_FOIA\\_Public\\_Liaison@hhs.gov](mailto:HHS_FOIA_Public_Liaison@hhs.gov)

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Office of Government Information Services  
National Archives and Records Administration  
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E-mail: [ogis@nara.gov](mailto:ogis@nara.gov)  
Fax: 202-741-5769

There are no charges in this instance because the billable costs are less than our threshold of \$25.

Sincerely yours,

*Nusheen Sikandar*

on behalf of Arianne Perkins  
Director, Initial FOIA Requests  
FOI/Privacy Act Division

Enclosure: Responsive record



U.S. Department of Health & Human Services

## **U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

### **REAL PROPERTY CAPITAL PLAN FY 2022**

**VERSION – FINAL**

**JANUARY 8, 2021**





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## PREFACE

This document is the U.S. Department of Health and Human Services (HHS) Real Property Capital Plan (RPCP) for fiscal year 2022, pursuant to the *Office of Management and Budget (OMB) Management Procedures Memorandum M-20-03, Implementation of Agency-wide Real Property Capital Planning*.



# HHS MISSION

*The mission of the U.S. Department of Health and Human Services is to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.<sup>1</sup>*

## INTRODUCTION

The U.S. Department of Health and Human Services (HHS) is the federal government's principal agency for protecting the nation's health and well-being; providing essential services, especially to those who are least able to help themselves. HHS improves the lives of all Americans by conducting biomedical research, preventing the outbreak of infectious disease, ensuring food and drug safety, administering Medicare, Medicaid, and Affordable Care Act programs, and numerous other important health and human service programs. HHS is comprised of 11 Operating Divisions (OPDIVs) and 17 Staff Divisions (STAFFDIVs), which are part of the Office of the Secretary (OS).

The OPDIVs are:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

The STAFFDIVs are:

- Office of the Secretary (OS)
- Office of the Assistant Secretary for Administration (ASA)
- Office of the Assistant Secretary for Financial Resources (ASFR)
- Office of the Assistant Secretary for Health (OASH)
- Office of the Assistant Secretary for Legislation (ASL)
- Office of the Assistant Secretary for Planning and Evaluation (ASPE)
- Office of the Assistant Secretary for Preparedness and Response (ASPR)
- Office of the Assistant Secretary for Public Affairs (ASPA)
- Office for Civil Rights (OCR)
- Departmental Appeals Board (DAB)
- Office of the General Counsel (OGC)
- Office of Global Affairs (OGA)
- Office of Inspector General (OIG)
- Office of Medicare Hearings and Appeals (OMHA)
- Office of the National Coordinator for Health Information Technology (ONC)
- HHS Chief Information Officer (CIO)

<sup>1</sup>HHS Strategic Plan FY 2018-2022. <https://www.hhs.gov/about/strategic-plan/index.html>

# CAPITAL PLANNING

## MISSION REQUIREMENTS FOR REAL PROPERTY

The Real Property Capital Plan (RPCP) is formulated to ensure the stewardship of real property aligns with the HHS mission and strategic goals.

*The mission of the U.S. Department of Health and Human Services is to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.*

The Fiscal Year 18-22 Strategic Plan describes HHS's efforts within the context of five broad Strategic Goals <sup>2</sup>:

*Strategic Goal 1: Reform, Strengthen, and Modernize the Nation's Healthcare System*

*Strategic Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play*

*Strategic Goal 3: Strengthen the Economic and Social Well-Being of Americans Across the Lifespan*

*Strategic Goal 4: Foster Sound, Sustained Advances in the Sciences*

*Strategic Goal 5: Promote Effective and Efficient Management and Stewardship*

Strategic Goal 4 addresses real property concerns albeit in general terms. Strategic Goal 4.2 notes <sup>3</sup>:

*HHS also invests in strengthening the research infrastructure, ensuring that research facilities are constructed, modernized, and equipped with state-of-the-art tools and resources to support the scientific community*

And,

*Core facilities are centralized shared resources that provide access to instruments, technologies, services, expert consultation, and other services to scientific and clinical investigators. The Department is strengthening core facilities and infrastructure capacity through the following strategies:*

*Leverage facilities as shared resources, which provide investigators access to advanced technologies through cutting-edge instrumentation operated by appropriately trained staff*

<sup>2</sup> HHS Strategic Plan FY 2018-2022. <https://www.hhs.gov/about/strategic-plan/overview/index.html>

<sup>3</sup> HHS Strategic Plan FY 2018-2022. [https://www.hhs.gov/about/strategic-plan/strategic-goal-4/index.html#obj\\_4\\_2](https://www.hhs.gov/about/strategic-plan/strategic-goal-4/index.html#obj_4_2)



*Ensure that the scientific research workforce has access to modern tools, including resources for data science and scientific computing*

*Support modernization and improvements of research facilities through alterations, renovations, and new equipment purchases*

To that effect, in order “to enhance the health and well-being of all Americans, by providing for effective health and human services” HHS leverages a blend of real property geared for specific purposes consisting of office, healthcare, housing and warehouse, and it uses laboratories and other facilities to “foster sound, sustained advances in the sciences underlying medicine, public health, and social services”.

To support the missions of more than 300 health-related programs staffed by more than 115,000 employees and contractors, HHS and its components own, lease, occupy or otherwise manage 3,772 buildings in over 59 million gross square feet (GSF) of space, providing over 45 million usable square feet (USF). The overall HHS portfolio consists of 4,162 real property assets<sup>4</sup>.

The Program Support Center (PSC) has oversight for the Department’s Real Property Portfolio which spans all OPDIVs and STAFFDIVs. Beyond PSC’s oversight responsibilities, PSC works closely with the non-landholding Divisions to acquire mission-related space. In addition to the landholding OPDIVs reporting on real property, PSC coordinates and reports on real property on behalf of all the STAFFDIVs belonging to the Office of the Secretary (OS) except for the Office of the Inspector General (OIG).

CDC, FDA, IHS and NIH have landholding authority and own, lease, or otherwise manage 3,786 assets (87.4% of the USF portfolio) under provisions of the Public Health Service Act (Title 42 U.S.C. §§201, et seq.). IHS has landholding authority under Public Law 67-85 (25 13). Each of these OPDIVs missions requires it to own and operate real property.

The Office of Refugee Resettlement (ORR) within ACF is responsible for housing unaccompanied alien children (UAC) who have entered the US without a parent or guardian. In 2019 the Department of Justice verified that ORR had landholding and direct lease authority due to the transfer of the program from the Immigration and Naturalization Service as a result of the Homeland Security Act of 2002. ORR does not currently own or lease any real property but may use this authority in the future.

Going forward in this document the OPDIVs and STAFFDIVs involved in real property management and/or reporting will be referred collectively as “Divisions”.

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<sup>4</sup> From HHS ARIS Database as of 11/20/2020, excluding Archived and Disposed properties.

## PROPERTY PORTFOLIO

The HHS Real Property Portfolio comprises of the following for calendar year 2020 <sup>5</sup>:

Land Usage	Acres	% of Portfolio
Family Housing	73	1.2%
Institutional	4,637	77.8%
Land	750	12.6%
Office	486	8.1%
Other	18	0.3%
<b>Totals</b>	<b>5,964</b>	<b>100.0%</b>

Ownership Type	USF	% of Portfolio
Direct Leased	7,666,556	16.9%
Direct Owned	21,837,221	48.1%
GSA Leased	10,294,237	22.7%
GSA Owned	5,435,666	12.0%
Inter-Agency Agreement	198,428	0.4%
<b>Totals</b>	<b>45,432,110</b>	<b>100.0%</b>

Building Sub-Type	USF	% of Portfolio
Office	16,850,203	37.1%
Laboratories	10,036,290	22.1%
Outpatient Healthcare Facility	6,328,820	13.9%
Hospital	4,175,670	9.2%
Family Housing	3,397,511	7.5%
Warehouse	1,960,721	4.3%
Other	2,682,894	5.9%
<b>Totals</b>	<b>45,432,110</b>	<b>100.0%</b>

USF = Usable Square Feet.

<sup>5</sup> From HHS ARIS Database as of 11/20/2020, excluding Archived and Disposed properties.



The complete Building Sub-Type breakdown is as follows:

Building Sub-Type	USF	% of Portfolio
Office	16,850,203	<b>37.1%</b>
Laboratories	10,036,290	<b>22.1%</b>
Outpatient Healthcare Facility	6,328,820	<b>13.9%</b>
Hospital	4,175,670	<b>9.2%</b>
Family Housing	3,397,511	<b>7.5%</b>
Warehouse	1,960,721	<b>4.3%</b>
Border/Inspection Station	794,205	<b>1.7%</b>
Institutional	536,736	<b>1.2%</b>
Service	459,309	<b>1.0%</b>
Other	386,535	<b>0.9%</b>
Industrial	331,828	<b>0.7%</b>
Facility Security	67,103	<b>0.1%</b>
Childcare Center	41,529	<b>0.1%</b>
Land Port of Entry	37,021	<b>0.1%</b>
Communications Systems	13,317	<b>0.0%</b>
Public Facing Facility	8,098	<b>0.0%</b>
Dormitories	5,010	<b>0.0%</b>
Data center	2,204	<b>0.0%</b>
<b>Totals</b>	<b>45,432,110</b>	<b>100.0%</b>

USF = Usable Square Feet.



## MISSION ALIGNMENT

The HHS Real Property Portfolio includes assets leased by all Divisions and assets owned by the landholding OPDIVs: CDC, FDA, IHS and NIH.<sup>6</sup>

The CDC, through its Centers, Institutes and Offices, develops and applies disease prevention and control, environmental health, and health promotion and health education activities designed to improve the health of the people of the United States. The CDC is headquartered in Atlanta, GA, with other locations in 11 U.S. states and territories.

The FDA protects and promotes public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, food, cosmetics, and products that emit radiation; and is responsible for regulating the manufacturing, marketing, and distribution of tobacco products. The FDA has field offices and laboratories located throughout the 50 states, U.S. Virgin Islands, and Puerto Rico. The FDA is headquartered in the White Oak Campus in Montgomery County, MD. The White Oak Campus is occupied through occupancy agreement with GSA.

The IHS provides comprehensive health services to American Indian and Alaska Native members of the federally recognized tribes located throughout the United States. The IHS operates hospitals, health centers, health stations, and staff housing across the U.S. The IHS maintains regional headquarter locations across the US.

The NIH, through its Institutes and Centers, is the nation's leading medical research agency, improving health and saving lives. The NIH conducts research in its own laboratories and supports research of non-federal scientists in universities, medical schools and hospitals throughout the U.S. and abroad. This research is primarily conducted at NIH campuses in Maryland, North Carolina, Arizona, and Montana. The NIH is headquartered in the Bethesda Campus in Montgomery County, MD. Most of HHS's direct leased space is special purpose space held by NIH. NIH has authority to acquire space based on mission requirements, and these acquisitions can be funded by the Institutes and Centers.

The Office of the Secretary, Staff Divisions and non-landholding OPDIVs primarily occupy office space either leased or owned by GSA. The Humphrey Building in Washington, DC, serves as HHS Headquarters. The Humphrey Building is part of the Southwest Complex that also includes the Switzer and Cohen Buildings. 5600 Fishers Lane, in Montgomery County, Maryland, serves as a satellite headquarters location.

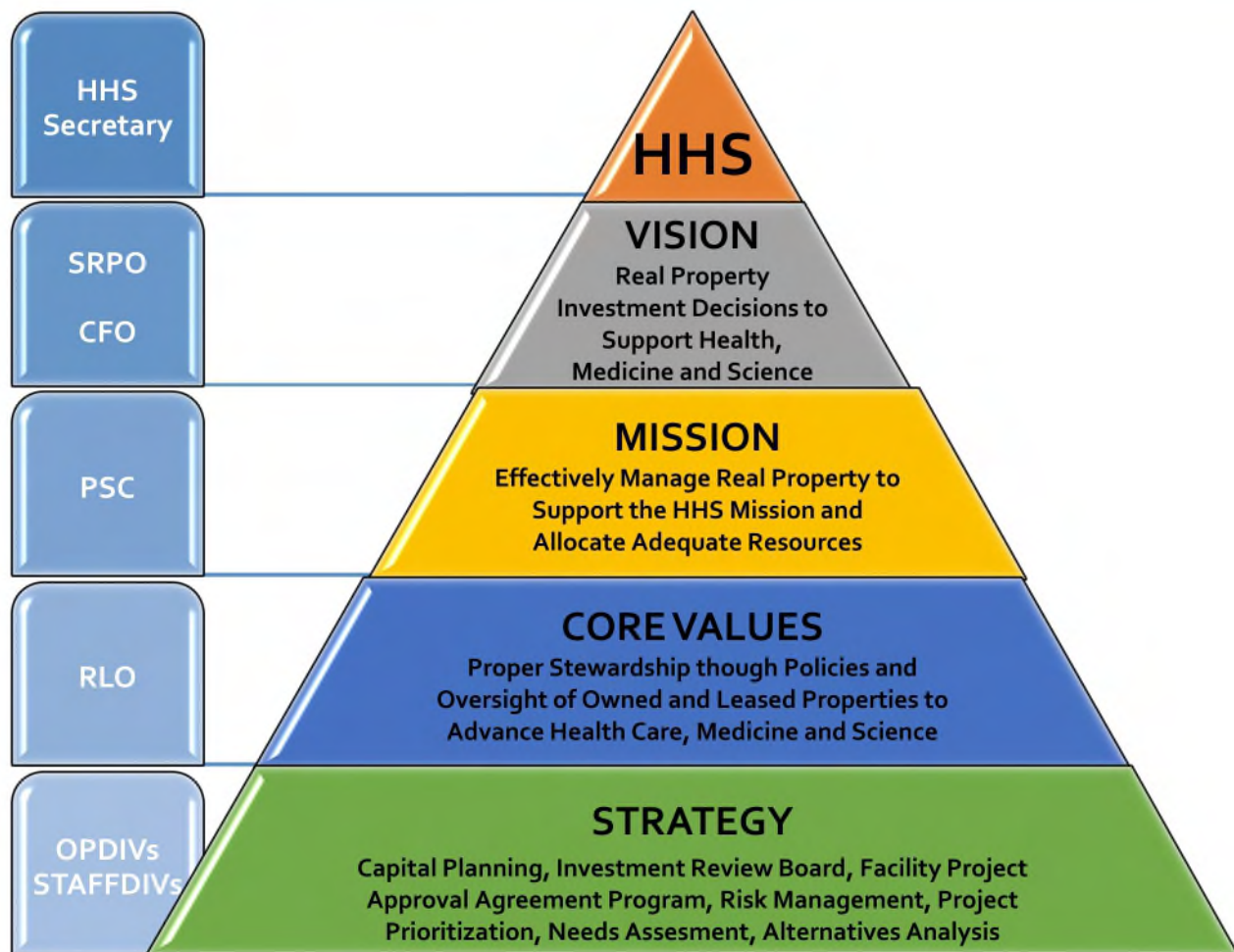
The CMS is headquartered in four GSA-owned buildings in Baltimore County, Maryland. CMS also maintains space in the Humphrey Building and in numerous field offices across the US. HHS also maintains ten regional offices located in major metropolitan areas across the US. Each regional office is led by a President-appointed Regional Director. The Secretary's Regional Directors ensure the Department maintains close contact with state, local, and tribal partners and addresses the needs of communities and individuals served through HHS programs and policies.

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<sup>6</sup> HHS Real Property Efficiency Plan FY20-FY24.



## PORTFOLIO MANAGEMENT



**It is important to note that some Divisions have their own Division Capital Plans and facilities staff who do the daily-decision-making and day-to-day work of managing the Real Property Portfolio (Facilities and Design and Construction projects) through their own internal processes, as this responsibility has been delegated to them by HHS.**

It is also important to note that not all Divisions that are involved in managing real property produce Division Capital Plans, and the lack thereof has been identified as a planning gap intended to be addressed in the short-term. It is expected by the Department that not all Divisions will produce or necessitate robust plans such as those produced by landholding OPDIVs. However, adoption of this practice by all Divisions is expected to result in improved planning and forecasting across the entire HHS Real Property Portfolio.

## MANAGEMENT TOOLS

The primary tools used by HHS to manage its Real Property Portfolio at the Division and Department level include: <sup>7</sup>

- 1) Facilities Program Manual and Budgeting Tools
- 2) Automated Real Property Inventory System
- 3) Division Master Plans
- 4) Division Five-Year Timelines
- 5) Division Sustainment Programs
- 6) Division Real Property Capital Plans
- 7) HHS Capital Investment Review Board
- 8) HHS Five-Year Timeline
- 9) HHS Real Property Capital Plan

## FACILITIES PROGRAM MANUAL

The Facilities Program Manual (FPM) applies to the management, planning, programming, budgeting, approval, acquisition, development, improvement and delivery of HHS facilities, and cover(s) operations, maintenance, and disposal of HHS real property<sup>8</sup>.

The policy contained in the FPM is applicable to all HHS organizations (Operating Divisions and Staff Divisions) responsible for management of leased or owned or otherwise managed real property assets.

### Project Planning Tools

The FPM establishes the required processes and recommended tools intended to help formulate and define capital improvement projects scopes and budgets utilizing industry standard practices. Brief descriptions of the planning tools used is presented below.

### Facility Project Approval Agreement

For all projects exceeding established budget thresholds, the Department requires that each Division have an internal process for identifying projects, developing, evaluating and documenting the business case, and prioritizing said projects for inclusion in their Division Capital Plans. For this purpose, the Divisions are required to complete a *Facility Project Approval Agreement (FPAA - HHS Form 300)* - a written agreement between designated OPDIV officials (i.e., Project Manager, Project Director and OPDIV Board Member) and the Department evidencing the OPDIVs commitment to execute a particular project. ... The FPAA documents the project's scope and description, basis of need, funding source(s), and total cost from all sources. It identifies project schedule milestones, including completion of design, construction, activation and operational phases." <sup>9</sup>.

Divisions are required to use the HHS Facility Project Approval Agreement (FPAA) form to submit justifications for proposed projects to the Department. FPAAs are based on OMB Exhibit 300. The justifications must address project scope, budget, schedule and compliance with federal regulations. FPAAs are reviewed and approved or rejected by RLO and ASFR staff.

<sup>7</sup> HHS Real Property Efficiency Plan FY20-FY24.

<sup>8</sup> HHS Facilities Program Manual, Draft, 2021 (superseding 2011 version).

<sup>9</sup> From NIH Facilities Development Manual, Version 5, Section 1-4.



**HHS FACILITY PROJECT APPROVAL AGREEMENT**

1. Project No. (ID) 2. Revision No.

3. Project Title 4. Budget Year: 5. Date (mm/dd/yyyy)

6. Total BAF Cost (\$M) 7. Total Project Cost (\$M)

8. OPD/Program Office 9. Institution/Location (City & State)

**10. Facility Cost Estimate (\$M)**

Item	Amount	Fund Source	Fiscal Year
a. Land Acquisition	\$ -		
b. Design (DB)	\$ -		
c. Construction (DB)	\$ -		
d. Equipment	\$ -		
e. Other	\$ -		
f. Total Facility Cost Est.	\$ -		

**11. Related Cost Estimate (\$M)**

Item	Amount	Fund Source	Fiscal Year
a. Special Studies	\$ -		
b. Pre-project Planning	\$ -		
c. Activation (include moving)	\$ -		
d. Special Purpose Equipment	\$ -		
e. Other	\$ -		
f. Total Related Cost Est.	\$ -		

12. OP-Site Utilities required: ☐ Yes ☐ No

13. Project Description (Scope/Quantity)

14. Justification

15. Project Requirements

16. Real Property Asset Management: This project directly supports the Real Property Initiative to right size the HHS inventory. ☐ Yes ☐ No

17. Project completion FY/PC method will change:

- Mission Dependency from: To
- Utilization status from: To
- Condition Index from: To
- Operating Costs from: To

18. Total BNAF reduction is: ☐ Yes ☐ No

19. Sustainable Design: This project meets the Guiding Principles of the Federal Leadership in High Performance and Sustainable Buildings Memorandum of Understanding (EPA 2005, EPA 2007 and EO 13524).

20. FAC/HRM: Project manager has been validated according to FAC/HRM or GAMA criteria as qualified for this investment.

21. Schedule (Month/Year)

Item	Start	Complete	Authority	Signature	Date
a. Studies					
b. Planning			a. Project Manager		
c. Design (DB)			b. Project Director		
d. Construction (DB)			c. OPD/ Board Member		
e. Activation			d. Office of the Secretary		
f. Operational					

HHS Form 300 (20210)

**FIGURE 1. FPA - HHS FORM 300**

## Project Definition Rating Index

The Project Definition Rating Index (PDRI) is a pre-project planning tool developed by the Construction Industry Institute (CII) that measures how complete the project scope has been defined<sup>10</sup>. The PDRI score is required as part of the submission of the FPA.

## Project Delivery and Contract Strategy

The Project Delivery and Contract Strategy (PDCS) tool or similar evaluation must be conducted to assist in determining the best method for project delivery. This process should feed into the development of the Acquisition Plan, which defines how the project will be executed, including tailoring general requirements and processes to the specifics of the project<sup>11</sup>. The evaluation through PDCS or a similar tool is required as part of the submission of the FPA.

## Economic Analysis

An Economic Analysis (ECONPACK) is developed for the project alternatives solutions. Analysis typically includes a status quo alternative.<sup>12</sup> An economic analysis needs to be developed to determine the viability of the venture and evaluate the various alternatives to meet the project requirement. The analysis should clearly show multiple equivalent alternatives and acknowledge the uncertainties of the analysis.<sup>13</sup> The evaluation through an ECONPACK is required as part of the submission of the FPA.

<sup>10</sup> From HHS Facilities Program Manual, 2011, Section 2-4.

<sup>11</sup> From NIH Facilities Development Manual, Version 5, Section 2-4.

<sup>12</sup> From NIH Facilities Development Manual, Version 5, Section 2-4.

<sup>13</sup> From NIH Facilities Development Manual, Version 5, Exhibit X2-4-A, A4.

## Sustainability Checklist

The Sustainability Checklist documents project requirements such as employing integrated design principles, optimizing energy performance, protecting and conserving water, enhancing indoor environmental quality, and reducing environmental impact of materials. The Sustainability Checklist is required as part of the submission of the FPAA.

The Sustainability Checklist follows the requirements set forth in the Council on Environmental Quality, *Guiding Principles for Sustainable Federal Buildings and Associated Instructions*, December 2020, which supersedes the 2011 version.

## AUTOMATED REAL PROPERTY INVENTORY SYSTEM

The Automated Real Property Inventory System (ARIS) is a database of all HHS real property data that is used to help develop and direct real property strategies to support the Department's diverse missions. ARIS data is used for the annual Federal Real Property Profile Management System (FRPP MS) reporting and for departmental real property planning and oversight. The ARIS is updated quarterly by the Divisions and by PSC. All data presented in this RPCP is obtained and/or transformed from the ARIS data snapshot dated 11/20/2020.

## DIVISION MASTER PLANS

Landholding OPDIVs are required to provide 20-year Master Plans for their various campuses in accordance with the FPM Section 3. The Master Plans are updated every five years and are submitted to the National Capital Planning Commission (NCPC) where applicable. Examples are provided below:

### CDC – Roybal Campus 2025 Master Plan

A new long-range Master Plan was prepared to guide the future physical development of the Roybal Campus for the planning horizon of 2015 to 2025 in order to support HHS/CDC's mission and program requirements. The Master Plan identifies a number of potential improvements to be completed through the 2015 to 2025 timeframe and establishes design and planning guidelines. Improvements proposed under the Master Plan include new laboratory construction, existing building renovation, parking expansion, and infrastructure upgrades.<sup>14</sup>

### IHS – Area Health Services and Facilities Master Plans

The Indian Health Service is divided into 12 physical areas of the United States: Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma, Phoenix, Portland, and Tucson. Each area has a unique group of tribes that they work with on a day-to-day basis. The physical areas are comprised of regional areas referred to as service units. Service units are located across the territories and contain facilities ranging from small ambulatory care clinics to full-service hospitals. Most of the facilities are located on Indian reservations. IHS planning guidelines are used to instruct areas and tribes on the development of Area Health Services and Facilities Master Plans.<sup>15</sup>

<sup>14</sup> Final Environmental Impact Statement, Roybal Campus 2025 Master Plan, August 2014.

<sup>15</sup> From ihs.gov website and IHS Facilities Report to Congress, Sec 301, IHCIA, July 29, 2013.



## FDA – 2018 Master Plan for the Consolidation of the U.S. FDA Headquarters at the Federal Research Center at White Oak Located in Silver Spring, Maryland

Due to new Congressional mandates, FDA is projecting a significant increase in employees and campus support staff at the FDA Headquarters. Therefore, the 2018 Master Plan's purpose is to plan for future growth and further consolidate FDA operations. The Master Plan will provide a framework for development at the FRC to accommodate another 7,018 FDA employees and support staff on site for a total population of 18,000 FDA employees and support staff. ... A Master Plan is needed to continue to support the FDA Headquarters consolidation at the FRC and provide the necessary office space to conduct the complex and comprehensive reviews mandated by Congress.<sup>16</sup>

## NIH – 2013 Comprehensive Master Plan NIH Bethesda Campus

The Master Plan is focused on NIH's scientific mission. It is a vision of where the NIH aspires to be scientifically in the next 20 years at its Bethesda Campus and serves as a tool to achieve that vision. The Master Plan is aligned with NIH's mission to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce the burdens of illness and disability. As a vision, the Master Plan promotes scientific collaboration by organizing the campus into research clusters. ... The Master Plan provides a blueprint to ensure that capital investments, should they be funded, are consistent with a long-term vision of the campus and respectful of the region, the community, traffic, pedestrian safety, the environment, historic preservation, sustainability and other key factors.<sup>17</sup>

## DIVISION FIVE-YEAR TIMELINES

Divisions update and submit Five-Year Timelines (5YTLs) to PSC Real Estate Logistics and Operations (RLO) semi-annually. Division 5YTLs are used to plan and track all projects and changes to the footprint of real property inventory including acquisitions, renovations and disposals, and improvement of office efficiency use. Division 5YTLs are also used to track project changes to the office and warehouse inventory related to the Reduce the Footprint initiative

## DIVISION SUSTAINMENT PROGRAMS

Sustainment Programs are submitted by the Divisions with the annual budget requests. They forecast changes to the Backlog of Maintenance and Repair (BMAR) and Facility Condition Index. Failure to adequately fund sustainment, maintenance and repair has been an ongoing issue for HHS; this and other capital planning gaps are discussed later in this document.

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<sup>16</sup> 2018 FDA Master Plan, Federal Research Center, September 2018.

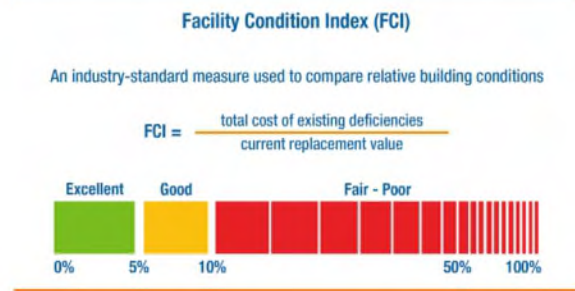
<sup>17</sup> 2013 Comprehensive Master Plan NIH Bethesda Campus, June 2013.



## Backlog of Maintenance and Repair

The Backlog of Maintenance and Repair (BMAR) needs for the Direct Owned Buildings are very high nearing \$2.8 Billion dollars to date.

HHS follows GSA in using the Condition Index (CI = 1-FCI<sup>18</sup>) to track the condition of the Direct Owned Buildings which is very low compared with industry benchmarks. For example: 46.5% of CDC, 54.5% of FDA, 28.5% of IHS and 74.9% of NIH buildings have a CI less than 90 (FCI higher than 10%<sup>19</sup>) which qualifies them as in **poor condition**.



HHS has set forth a target CI of 90 or above (FCI of 10% or less) for all buildings across its Direct Owned portfolio.

OPDIV	Direct Owned Assets	Replacement Value	Repair Needs
CDC	159 \$	3,892,568,923 \$	180,162,519
FDA	77 \$	494,088,179 \$	56,681,432
IHS	2,115 \$	2,256,454,365 \$	432,568,282
NIH	271 \$	10,652,985,068 \$	2,121,429,508
<b>Totals</b>	<b>2,622 \$</b>	<b>17,296,096,534 \$</b>	<b>2,790,841,741</b>

**FIGURE 2. COMPREHENSIVE BMAR NEEDS (REPAIR NEEDS) TO DATE**

## Condition Index, Sustainment and Improvement Funding Plan

The Condition Index, Sustainment and Improvement Funding Plan (CISIFP) tracks the condition of owned assets and establishes a long-term funding plan to sustain and improve them. The Department's CI target is 90 or above, with a goal of 2% to 4% of the Functional Replacement Value (FRV) or Plant Replacement Value (PRV) for annual reinvestment in maintenance, repair and sustainment. Divisions with buildings with CI significantly below the target should request 3% to 4% of PRV in annual funding requests.

## DIVISION REAL PROPERTY CAPITAL PLANS

Divisions employ the same capital planning process, which is consistent with OMB Circular No. A-11. They utilize integrated project teams to identify potential capital improvement options and analyze and evaluate them against Division strategic goals and other specific criteria.

Division Real Property Capital Plans (formerly known as Building and Facilities plans) include a detailed narrative of the Divisions' planning procedures for all owned and leased real property, and a prioritized list of proposed acquisition and construction, maintenance and operations, and disposal projects – these stages align with GSA requirements on real

<sup>18</sup> Illustration from: <https://www.accruent.com/solutions/capital-planning/facility-condition-assessments-vfa>

<sup>19</sup> Higher percentages indicate lower Facility Condition Index.

property capital planning. The Plans identify current and future capital improvement projects planned based on mission need, as well as Sustainment Programs.

The Plans span a five-year forward planning timeframe, i.e. the Plans show prioritized projects that are requested for funding in the current budget year plus five years forward. The Plans also show projects previously funded over the past 3 years. For example, the fiscal year 2022 Plans include the fiscal year 2019 through fiscal year 2027.

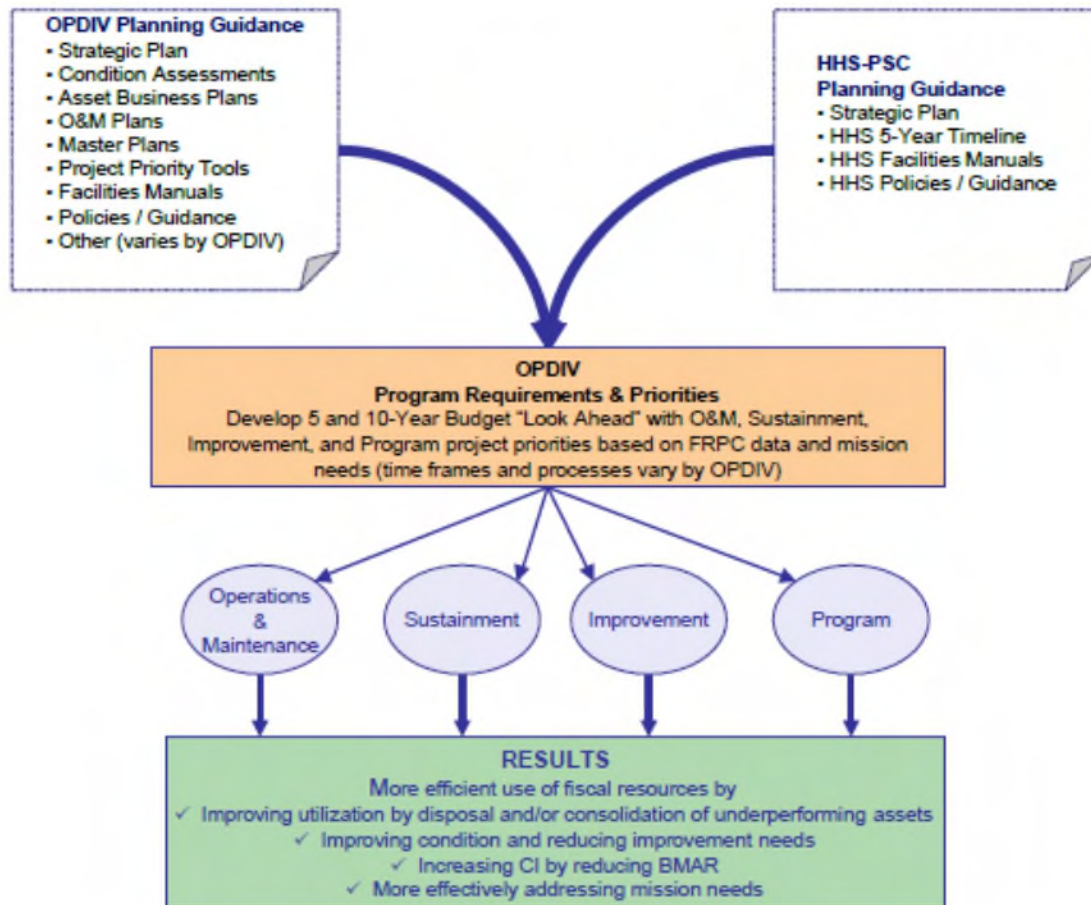
The Plans identify funding requests for capital improvement project (construction, repair-by-replacement, major repairs, major improvements, tenant improvements for lease actions and projects for disposal) prioritized by the Divisions, as well as lump sum appropriations requests for Sustainment Programs. These funding requests are submitted as part of the annual budget formulation process and are used in planning future funding requests. HHS reviews individual projects and lump sum funding requests while understanding programmatic priorities and the impacts of approving or deferring the facility work.

Capital improvement projects with budgets of \$1 million or more are submitted to the Department for review and approval. The Senior Real Property Officer (SRPO) is authorized to review and approve capital improvement projects costing between \$1 million and \$10 million, while projects costing above \$10 million (\$20 million for IHS) must be reviewed and approved by the Capital Investment Review Board (CIRB). The SRPO and CIRB do not determine if and how projects are funded. These determinations are made by the Office of the Secretary based upon recommendations provided by the SRPO, CIRB and ASFR.

**Information from the Divisions 5YTLs, Sustainment Programs and Real Property Capital Plans is used to inform the HHS 5YTL and HHS RPCP.**



A diagram of this effort is presented below:



**FIGURE 3. DIVISION PLANNING AND RESULTS PROCESS**

## CAPITAL INVESTMENT REVIEW BOARD

The Capital Investment Review Board (CIRB) was established in 2003 to make recommendations for strategic management of HHS real property assets and to advise the ASA, ASFR and the Secretary. The CIRB meets twice a year to review proposed capital improvement projects and master plans. HHS-wide strategic goals are incorporated into the CIRB's decision criteria. This board structure is consistent with the OMB Circular A-11 requirements for an Executive Review Committee.<sup>20</sup> The CIRB is composed of the following members:

- Assistant Secretary of Administration (ASA)
- Senior Real Property Officer (SRPO)
- Assistant Secretary for Financial Resources (ASFR)
- Assistant Secretary for Legislation (ASL)

<sup>20</sup> HHS Real Property Efficiency Plan FY20-FY24.

- Assistant Secretary for Planning and Evaluation (ASPE)
- Director of the CDC
- Commissioner of FDA
- Director of IHS
- Director of NIH

Capital planning requirements specified in the HHS Facilities Program Manual and annual ASFR budget preparation instructions are the basis for individual Division Capital Plans and budgets development. Divisions determine their annual real property needs and submit their requests through their budget offices to ASFR. ASFR reviews budget submissions with assistance from the SRPO and submits recommendations to the Office of the Secretary. Proposed real property capital improvement projects must be approved by either the SRPO or the CIRB, depending on the project budget.

## HHS FIVE-YEAR TIMELINE

The HHS Five-Year Timeline (HHS 5YTL) is used primarily to identify strategic opportunities for consolidation and disposal of assets, and to plan and track all changes to the real property inventory including acquisitions, renovations and disposals, and improvement of office efficiency, which fall above established budget thresholds at the Department level.

## HHS REAL PROPERTY CAPITAL PLAN

Starting 2020, the results from all the tools and efforts described above provide the information used to inform the HHS Real Property Capital Plan (RPCP). The RPCP includes a prioritized list of acquisition and construction, operations and maintenance, and disposal projects, and sustainment programs necessary to support the HHS mission.

The RPCP will be updated annually and submitted pursuant to OMB in accordance with Management Procedures Memorandum M-20-03, Implementation of Agency-wide Real Property Capital Planning.

The RPCP will undergo review and comment by the Federal Real Property Council (FRPC), by way of multiple federal agencies providing review and feedback on the content, practices and processes showcased in the RPCP. This feedback will be used by HHS to improve upon the plan itself but most importantly upon the practices described herein.



## SENIOR ROLES AND RESPONSIBILITIES

HHS employs a variety of senior roles to accomplish its capital planning efforts throughout the year and relies on multiple stakeholders from the within the Department and the different Divisions.

### SRPO RESPONSIBILITIES

In accordance with OMB M-18-21 Designation and Responsibilities of Agency SRPO (July 12, 2018), under the authority of the Assistant Secretary for Administration (ASA), the PSC Director is the HHS Senior Real Property Officer (SRPO), pursuant to EO 13327, "Federal Real Property Asset Management" (February 4, 2004). The PSC Director has the delegated authority of the ASA for the implementation of HHS real property planning and policy, environmental and safety compliance, real estate leasing, real property disposal, and the HHS Sustainability Program<sup>21</sup>. The SRPO:

1. Serves as asset manager for the Department in support of the HHS Strategic Plan;
2. Identifies and categorizes HHS owned, leased, or managed real property; maintains the ARIS program, and submits reports to the Federal Real Property Profile Management System.
3. Provides facilities-related technical assistance and reviews Division real property-related budget submissions for ASFR;
4. Issues Department-wide real property related policy and ensures compliance with HHS and federal real property requirements and goals;
5. Approves all space disposal and acquisitions and campus master plans, in consultation with the ASFR;
6. Oversees HHS components' real property strategy, prioritizes actions to improve the operational and financial management of agency real property inventory, and identifies and measures progress towards those goals; and,
7. Approves major capital improvement projects up to the Capital Investment Review Board (CIRB) level and advises the CIRB on major, program-wide decisions.

While the SRPO reviews and approves new space acquisitions to ensure policy compliance, the SRPO does not direct disposition of buildings or other real property. Day-to-day asset management responsibility is delegated to the Divisions. This includes space acquisitions through GSA and facilities management and construction program management for landholding OPDIVs. The SRPO exercises oversight of all HHS real property through implementation of Department-wide policy. For example, the HHS-wide administrative space utilization policy of 170 useable square feet (USF) per person is used to drive Divisions improve space utilization and to dispose of unneeded real property. All office space acquisitions, renovations, and Occupancy Agreement (OA)/lease renewals are required to comply with this policy and must be approved by the SRPO. Divisions submit housing plans to RLO for review and SRPO approval, and RLO monitors these portfolio changes against the 5YTL. If there is a mission requirement or other circumstance that might preclude implementation of the space utilization policy, Divisions must submit a waiver request to the SRPO.<sup>22</sup>

<sup>21</sup> HHS Facilities Program Manual, Draft, 2021.

<sup>22</sup> HHS Real Property Efficiency Plan FY20-FY24.

## CFO RESPONSIBILITIES

Under the Secretary's authority, the ASFR provides advice and guidance to the Secretary on budget, financial management, acquisition policy and support, grants management, and small business programs. It also directs and coordinates these activities throughout the Department. The ASFR is the Department's CFO.

ASFR is a member of the Capital Investment Review Board and has voting authority on the investment decisions. ASFR staff routinely review the FPAA's for accuracy of the financial information provided in them. ASFR staff work with RPMS staff in reviewing budget requests from the Divisions. ASFR staff review the Division Capital Plans provided during the budget process and provide feedback to the Divisions and PSC staff.

ASFR facilitates the Secretary's Budget Council meetings where final investment decisions are made.

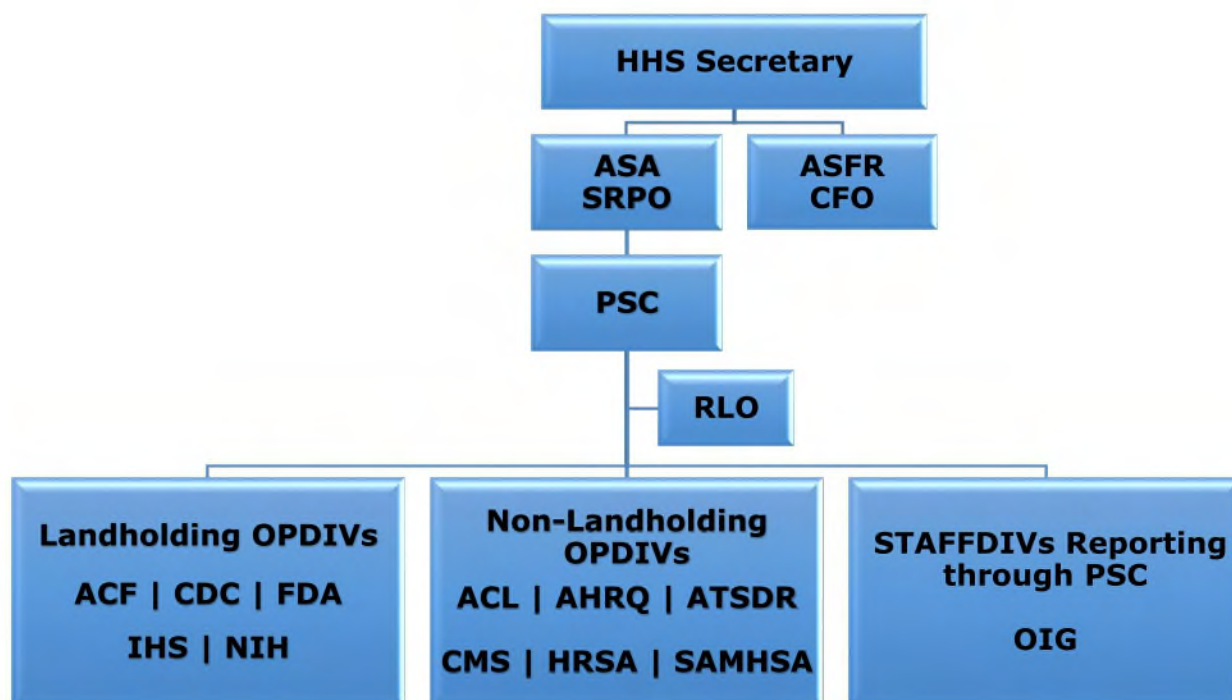
## RESPONSIBILITY MATRIX

As noted, before, some Divisions have their own Division Capital Plans and facilities staff who do the day-to-day work of managing the Real Property Portfolio through their own internal processes, as this responsibility has been delegated to them by HHS.

The majority of real property actions pertaining to specific day-to-day management, are accomplished at the Division level. The SRPO, as the visible single point of authority and control at the Department level, manages the HHS portfolio of real property assets. The SRPO is responsible for ensuring that Divisions are in compliance with HHS policies and other federal real property requirements whether through law, executive order or otherwise stipulated. As such, the SRPO is also responsible for providing an adequate workforce within RLO that can lead and direct the Divisions in functional areas of expertise to effectively and efficiently manage the HHS portfolio of assets for which they are accountable. The SRPO, through PSC, works directly with the Divisions and a snapshot of this working relationship is provided in the chart below.







**FIGURE 4. RESPONSIBILITY MATRIX**

## ANNUAL BUDGET PROCESS

Every spring, the HHS budget guidance call requests that each Division include in their Division Capital Plans all projects requiring SRPO or CIRB approval, which are those projects which exceed the budget thresholds of \$1 million (\$5 million for IHS) for new construction, \$2 million (\$10 million for IHS) for improvements and \$5 million (\$15 million for IHS) for repairs. Projects below these budget thresholds, for which the Divisions have delegated approval authority, may be included in the Division Capital Plans at their discretion; these projects are typically funded from the sustainment lump sum appropriations.

In addition, capital improvement projects costing \$10 million (\$20 million for IHS) or more are required to be submitted for review and approval to the CIRB; they must be designed and constructed with funds specifically identified by project name in the annual budget process documents; and they should be a congressional programming action, an actual line item appropriation in the President's budget or an OMB approved apportionment.

RLO supports the Office of the Assistant Secretary for Financial Resources (ASFR) during the budget formulation process by providing analysis and review of facilities related budget submission content.



## BUDGET CYCLE

The yearly Budget Cycle is structured as follows and generally abides to the established timeframes and dates. Calendar Year 2020-2021 being a presidential transition year may require some activities to shift to the spring of 2021.

Budget Activity	FY22 Timeframes and Dates
Division Prepares Preliminary Program Priorities	January 10, 2020
HHS OB/PSC Memorandum	April 21, 2020
HHS (and OMB) Budget Guidance	April 22, 2020
Division specific Budget Guidance	May 17, 2020
Division Submits Budget Request to HHS Justification (HHSJ)	June 2, 2020
<i>Five-Year Plan, CISIFP, HHS Form 300</i>	<i>June 1, 2020</i>
HHS Reviews Division HHSJ	June – July 2020
<i>Capital Investment Review Board</i>	June 24, 2020
<i>Secretary's Budget Council</i>	June 28-July 21, 2020
OMB Final Budget Guidance	June 23, 2020
HHS Secretary's Final Decision to Division (for OMBJ)	Early August 2020
<i>HHS OMBJ Budget Guidance</i>	<i>July 26, 2020</i>
Division Finalizes OMBJ Submission	August 23, 2020
<i>Five-Year Plan, CISIFP, HHS Form 300</i>	<i>August 6, 2020</i>
HHS Budget Submitted to OMB	September 13, 2020
OMB Reviews HHS Budget	September – November 2020
OMB Passback and Appeal	November 29, 2020(planned)
OMB/HHS Negotiations and President's Decisions	December 2020
Congressional Justifications Prepared	January 2021
President's Budget Submitted to Congress	1 <sup>st</sup> Monday in February 2021
Congressional Budget Reviews	February – March 2021

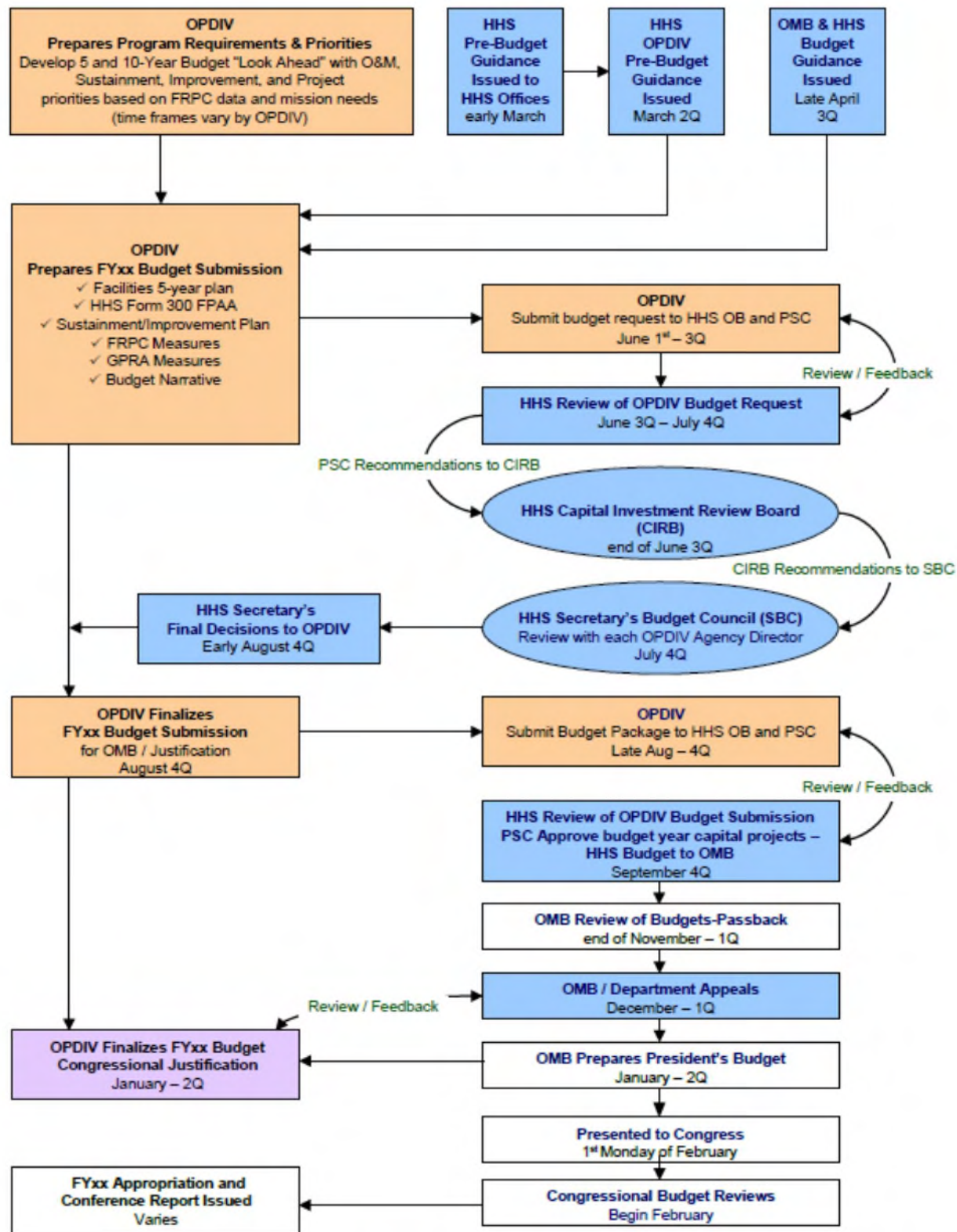


FIGURE 5. BUDGET CYCLE



## MAJOR LINES OF BUSINESS

Through more than 300 programs across its Divisions, HHS facilitates effective health care and human services and fosters advances in science and public health. With such a vital mission, it is important to work toward a clearly established vision: a future state where health care, public health, human services, and science programs work better for the Americans it serves.

HHS is the U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS accomplishes its mission through programs and initiatives that cover a wide spectrum of activities, serving and protecting Americans at every stage of life. HHS is responsible for more than a quarter of all federal outlays and administers more grant dollars than all other federal agencies combined. HHS accomplishes its mission through the facilities owned and operated or leased by HHS and its Divisions.

HHS owns and leases over 59 million gross square feet of buildings which can be accommodated into major groups as follows: Office, Healthcare (Hospitals and Outpatient Facilities), Housing (Family, Dormitory and Barracks), Laboratories, Warehouse and Other (Industrial, Service, Inspection Facilities, etc.)<sup>23</sup> With aging and outmoded infrastructure, many of the facilities owned by HHS are in need of upgrade and repairs.

Recapitulating and summarizing the individual missions of the Divisions:

- The CDC develops and applies disease prevention and control, environmental health, and health promotion and health education activities designed to improve the health of the people.
- The FDA protects and promotes public health by ensuring the safety, efficacy, and security of human and veterinary products and devices, and regulates the manufacturing, marketing, and distribution of tobacco products, through regulatory and inspection activities.
- The IHS operates hospitals, health centers, health stations, and staff housing across the U.S. serving American Indians and Alaska Natives.
- The NIH conducts research in its own laboratories, and supports research of non-federal scientists in universities, medical schools, and hospitals throughout the U.S. and abroad.
- STAFFDIVs provide administrative support to the OPDIVS and HHS programs across the U.S.

The major lines of business identified for Real Property Capital Planning are the management and right investment decisions of **Office, Healthcare, Housing, Laboratories and Warehouse**.

High level determinations of whether assets within the major lines of business have sufficient capacity to meet mission requirements are made based on Department-wide target utilization rates, and whether said utilization rates result in assets being utilized or underutilized. These targets, factors and formulas are discussed in the needs assessment section.

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<sup>23</sup> From HHS ARIS Database Real Property Use categories.



## NEEDS ASSESSMENT

The Real Property Portfolio needs assessments follow each Division's individual processes which generally consist of working groups and specialty committees consisting of voting and non-voting members, whose decisions and recommendations inform the different Division Capital Plans and submissions to HHS.

Common traits between the OPDIVs efforts are the inclusion of mission-critical stakeholders, such as tribes, scientific directors, administrative directors, and strategic and policy level authors, who establish mission-critical priorities informing long-range strategic plans that establish the desired portfolio characteristics to fulfill the individual mission requirements.

Needs assessments will include real property gaps in meeting mission-critical requirements and addressing space utilization, security, life-safety, regulatory (e.g., accessibility and accreditation such as Association for Assessment and Accreditation of Laboratory Animal Care International (AAALAC) and Bio-Safety Level 3 (BSL3) certification), and functional issues, legal/legislative imperatives, consequences of delay/omission and risk of failure, Condition Index impact and/or BMAR reduction, project timing and dependencies, funding sources and availability, useful life of investment, out-year funding needs, operating-cost impact, sustainment and sustainability.

Funding determinations also follow similar traits between the OPDIVs where projects are prioritized using OPDIV specific prioritization models, along with analysis of historical data and input from regional partners and industry experts, in order to select, rank and propose projects for funding.

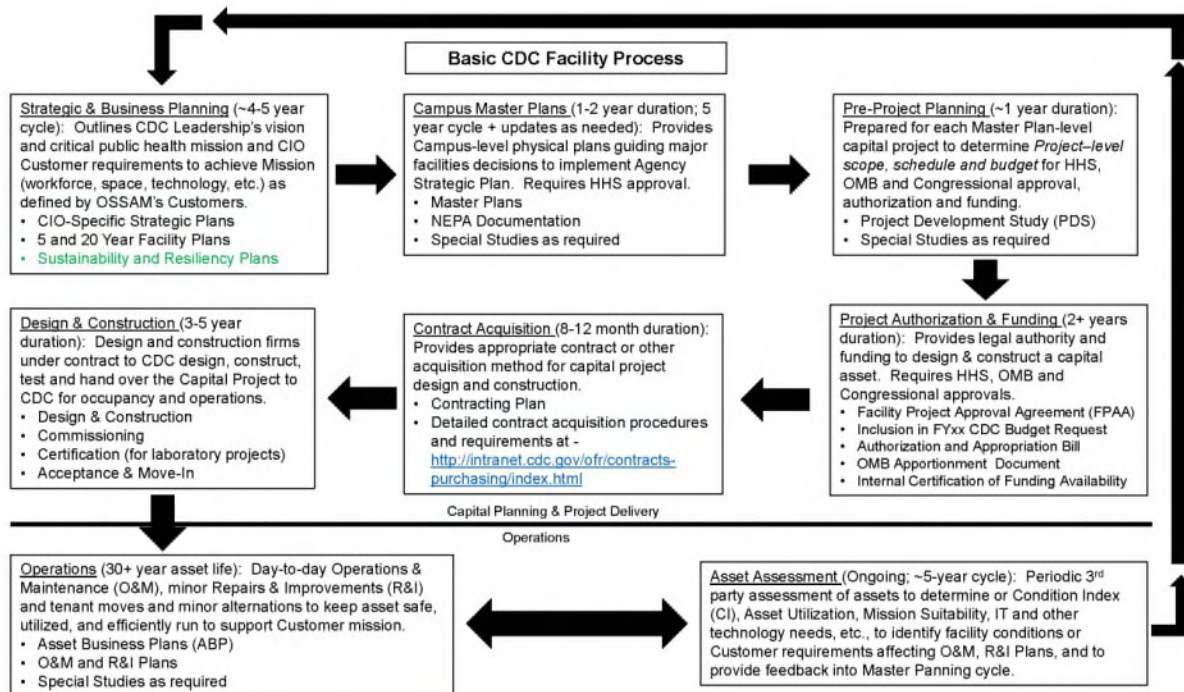
Two examples of these processes are presented below (not all processes from all the Divisions are presented in this document):

### THE NIH FACILITIES WORKING GROUP

*NIH staff presented the organization, structure, and general process of the Facilities Working Group (FWG) and its subcommittees to the National Academies of Sciences, Engineering, and Medicine committee: "The FWG is responsible for evaluating NIH's programmatic needs; balancing competing priorities; exploring alternative means of meeting NIH's changing needs for capital facilities; and reconciling them into a rolling five-year Strategic Facilities Plan [i.e., the B&F/NEF-Funded five-Year Plan], an annual Buildings and Facilities (B&F) Plan, and an annual Leased Facilities Plan." Membership in the FWG consists of 11 voting members and one nonvoting member. The group includes representation of Institutes and Centers (IC) directors, IC scientific directors, and executive officers from various ICs appointed by the Director of NIH for three-year terms. Two subcommittees operate under the FWG, the Space Recommendation Board (SRB) and the Budget Committee. Under the SRB is a Research Facilities Advisory Committee (RFAC). The FWG advises the NIH Director and NIH Steering Committee on the planning, acquisition, development, and use of land and facilities. The NIH Steering Committee was formed to provide advice and recommendations on trans-NIH governance issues. This committee is chaired by the NIH Director, who appoints IC directors as members.*<sup>24</sup>

<sup>24</sup> National Academies of Science, Engineering and Medicine: *Managing the NIH Bethesda Campus Capital Assets for Success in a Highly Competitive Global Biomedical Research Environment*, 2019, p 58.

## BASIC CDC FACILITY PROCESS



**FIGURE 6. BASIC CDC FACILITY PROCESS – SUMMARY DIAGRAM**

Efforts such as the NIH FWG and the CDC Facility Process <sup>25</sup> make up the bulk of the decisions and recommendations that inform the capital planning efforts at the Department level.

## DEPARTMENT TARGETS

Proper long-range (20-year Master Plans) and short-range (five-year) planning can be provided as a roadmap for the entire organization. This can be done by obtaining key data on assets such as future requirements of Science and Healthcare facilities requirements for the next five-year horizon, condition indices of existing facilities, backlog of maintenance and repairs, and by prioritizing requirements with full involvement of all levels of management.

In addition to the Divisions' needs assessments, the Department has set forth significant property target utilization rates, and utilization criteria that help guide the proposed outcomes in efficient use of the real property.

### Office

HHS Office Design Guidelines, developed with GSA, were issued March 25, 2016. They provide a framework for designing and planning HHS space to optimize healthy, comfortable, and productive workplaces, establish maximum suggested useable square feet by workstation type, and facilitate compliance with the HHS Reduce The Footprint (RTF)

<sup>25</sup> CDC Facilities 20-Year Strategic Plan, 2017 – 2037, p 11.



plan. HHS does not currently plan to revise the standard to generate greater office space efficiencies.

HHS established in 2011 a target utilization rate (UR) of 170 usable square feet (USF) per person on average for administrative office space applicable to all of HHS.

### Laboratories

The target UR for laboratories is 460 USF per person on average. New trends in scientific research require new types of laboratories and support facility design that are more open, adaptable and encourages cross disciplinary research rather than siloed laboratories of previous era. While a target UR is provided as guidance for Laboratories, these areas are often unique and depend on flexibility in capital planning in order to fulfill their mission.

A second trend impacting research infrastructure is the increased prominence of "big data". From a capital asset management perspective this underscores the criticality of communications networks to ensure timely and protected transfer of vast quantities of data and the dependence of these communications network on reliable power sources.

A third trend is the radical shifts in medical research equipment including the introduction of robot-assisted sample processing surgical equipment. This equipment is often larger than what was previous used, requiring increases in floor-to-floor height, load-bearing structural capacities, as well as increasing densities and loads on mechanical and communication services throughout the laboratories.

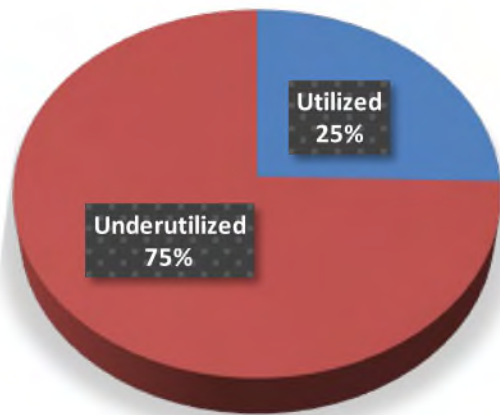
### Space Utilization Analysis

Per the 2020 HHS ARIS Guidance, buildings are reported as unutilized (zero occupants), underutilized, or utilized. The HHS policy for utilization for building types,<sup>26</sup> is based on the UR described prior or other methods specific to the building subtype, as follows:

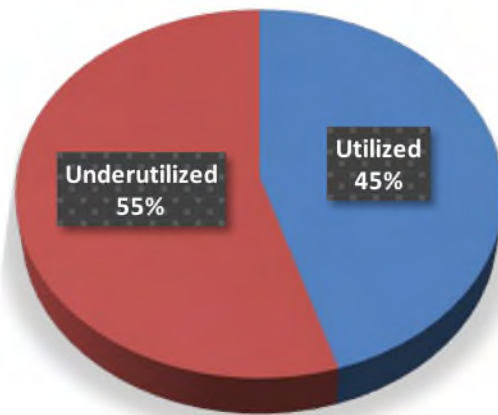
<b>Building Type</b>	<b>Formula</b>	<b>Underutilized</b>	<b>Utilized</b>
<b>Office</b>	USF/Occupant	> 170 USF/Occupant	≤ 170 USF/Occupant
<b>Healthcare</b>	Required program space* / existing space (as %)	< 80 %	> 80 %
<b>Housing</b>	Days occupied/Days available (as percent)	< 85 %	85 – 100 %
<b>Laboratories</b>	USF/Occupant	> 460 USF/Occupant	≤ 460 USF/Occupant
<b>Warehouse</b>	Space used / Design capacity (as percent)	< 50 %	> 50 %

<sup>26</sup> Based on the IHS Health System Planning (HSP) process

## Office



## Laboratories



The graphs above represent samples of 713 office properties and 157 laboratory properties. It is important to note that the results presented do not factor in any tolerances in the UR (i.e. +/- 0 USF/Occupant); reasonable tolerances to the target UR are readily apparent when analyzing and visualizing the data by other means, therefore, these results may differ from FRPP MS utilization reports that include properties reasonably qualified as utilized.

## ALTERNATIVES ANALYSIS

Alternatives analysis take different shapes and levels of sophistication at the different Divisions depending on the mission needs. Generally, the more sophisticated efforts will consist of assembling integrated project teams composed of subject matter experts (scientific directors, hospital administrators, architecture, engineering, real estate, safety, security, and IT professionals; program leaders and stakeholders; and other relevant parties), engaged in iterative planning and discussion processes, to define technical requirements aligned with mission-specific strategic priorities and facilities objectives.

These efforts will include feasibility studies, market surveys, preliminary cost-benefit and life-cycle analysis, and other tools to arrive at multiple alternatives. Alternatives are then identified, researched, and evaluated using a risk-adjusted cost-benefit analysis to arrive at the recommended solutions that best addresses strategic priorities and facilities objectives, appropriately mitigates risks and represents the best value to the taxpayer.

The recommended solutions are then further developed into conceptual designs and/or Programs of Requirements (POR), will undergo the FPAA process described above, in order to further define the needs and produce cost estimates that inform the review, approval and funding requests.

Less sophisticated planning efforts will include some of the same resources and tools mentioned above as dictated by the needs of the project, and they will share similar outcomes to those that the recommended solutions experience.



## PRIORITIZATION PROCESS

PSC follows a prioritization process rooted in a qualitative and quantitative model developed by NIH in 2019. The model is a 1,000 maximum point scoring system (270 minimum), where the higher the resulting score, the higher the priority the project will be awarded at the Department level.

The HHS model is intended to be broader reaching across all Divisions and includes four key criteria of consideration: mission dependency, asset management, sustainment, documentation, which are further described below. The model is intended to undergo improvements and restructuring of the assigned possible scoring values in 2021, and further refinement as needed and as the mission evolves. A key to properly using the model is to use the scores as fixed values and not as ranges, in order to mitigate subjective weighing and artificial ranking of the projects.

### MISSION IMPACT

The Mission Impact criteria focuses on whether the project being proposed qualifies as Direct Impact or Indirect Impact. Mission Direct Impact criteria is that which relates to the primary, secondary, tertiary or quaternary missions of HHS and its Divisions; the higher the mission being impacted, the higher the score assigned. Mission Indirect Impact criteria addresses the possible mitigation options available to satisfy the project intent; the tougher the mitigation possibility, the higher the score assigned. The Mission Impact criteria carries 300 points of the total possible score.

### ASSET MANAGEMENT

The Asset Management criteria focuses on Capital/Strategic Planning and Investment Risk Assessment factors. Capital/Strategic Planning criteria defines whether the project being proposed has been included (or not) in the Capital Planning efforts of the Department, and if it aligns (or not) with the Department Strategic Goals. Investment Risk Assessment criteria is that which seeks to ascertain that a thorough and complete risk assessment analysis has been performed, and what return (if any) is expected from the investment decision. The Asset Management criteria carries 300 points of the total possible score.

### SUSTAINMENT

The Sustainment criteria focuses on Backlog of Maintenance and Repair (BMAR) and Condition Index (CI) and how (and if) the project being proposed positively impacts and reduces the BMAR and increases the CI, or whether the project does nothing of substantial value to the facility, or whether the project does the opposite and negatively impacts the factors. The Sustainment criteria carries 300 points of the total possible score.

### DOCUMENTATION

The Documentation criteria focuses on the administrative requirements, reviews and approvals that the project being proposed must undergo at the Department, namely the Divisions Capital Plans, the CIRB and FPAA processes. Proper planning, inclusion, review and approval of the various processes, at the early stages of the projects, will command higher scores. The Documentation criteria carries 100 points of the total possible score.

## PRIORITIZATION MODEL

Capital Improvement Project Prioritization Model					
Criteria	Maximum Score	Sub-Criteria	Maximum Weight	Sub-Criteria Definition	Criteria Weight
Mission Impact	300	Direct Impact	150	Facilities that are primary to HHS Mission, e.g. Hospitals, Health Centers, Clinics, Public Health Institutions, Public Mission Resources, Emergency Response facilities and/or facilities that have significant policy implications or high executive visibility.	150
				Facilities that are secondary to HHS Mission, e.g. Research Facilities, Vivaria, Laboratories, Conference facilities, Warehouse etc.	100
				Facilities that are tertiary to HHS Mission, e.g. administrative, back of house facilities, other support services; and quaternary, e.g. storage, parking etc.	50
		Indirect Impact	150	Not mitigatable with relocation, repair, or telework; alternate service locations are not available, and other redundancies do not exist. Restoration is expected in an extended timeframe due to long lead facility attributes or special equipment or significant commissioning or validation requirements.	150
				Partially mitigatable with relocation, repair, telework; alternate service locations provide partial services, and/or other partial redundancies. Restoration is expected in typical timeframe.	100
				Fully mitigatable with relocation, repair, telework; adequate alternate services locations provide full services, and/or other full redundancies.	50
Asset Management	300	Capital Planning and Strategic Planning	150	The project is identified in the Division Real Property Capital Plan and supports the HHS Strategic Goals. The project has been identified in the Division Master Plan.	150
				The project is not in the current Division Real Property Capital Plan but will be submitted as an addendum to comply with M-20-03.	100
				The project is required for short-term needs only and is not part of the long-term HHS Strategic Goals.	50
		Investment Risk Assessment	150	A full investment analysis has been performed considering all viable alternatives and a decision has been made after considering life cycle cost estimates for each alternative. A cost-benefit analysis has been performed in accordance with OMB A-94. Where budgetary values cannot be determined are the non-budgetary values quantified or explicitly identified.	150
				The project has marginal returns on the investment.	100
				The project has high risk and low impact on HHS Mission.	50
Sustainment	300	Backlog Of Maintenance (BMAR) and Condition Index (CI)	300	The project supports policy requirements and HHS goals to reduce BMAR and improve CI as outlined in the Facilities Program Manual and/or Executive Orders.	300
				The project marginally contributes to BMAR reduction compared to the costs, or maintains the CI unchanged.	150
				The project substantially increases BMAR and lowers the CI and does not support HHS goals to increase CI above 90.	50
Documentation	100	Real Property Capital Plan	40	The project has been identified and approved in the Division Real Property Capital Plan submitted as part of the budget process.	40
				The project has been identified in a modification to the Division Real Property Capital Plan but not received approval yet.	20
				The project has not been identified in the Division Real Property Capital Plan or in any other part of the budget process.	10
		CIRB Approval	30	The project has been reviewed and approved by the CIRB.	30
				The project has been reviewed and approved by the CIRB but has significantly changed in Scope and/or Cost since its approval.	15
				The project has not been submitted for the CIRB review.	5
		FPAA Approval	30	The project has completed and submitted all FPAA documentation and has been reviewed and approved by PSC Director.	30
				The project is awaiting review and approval but has all required FPAA documentation in place.	15
				The project does not have any FPAA documentation prepared.	5



## PRIORITIZATION SCORING SHEET

The scoring sheet below shows the results of the Capital Improvement Project Prioritization Model for the projects submitted by the Divisions for fiscal year 2022 for HHS review and funding request.

The above-mentioned criteria scorecard presented is revised from the prior version used to generate the results below.

OPDIV	PROJECT		Mission Impact			Asset Management			Sustenance			Documentation				Total	Priority
			Direct Impact	Indirect Impact	Subtotal	CP/SP	Risk	Subtotal	Sustenance	BMAR	Subtotal	AFP	CIRB	FPAA	Subtotal		
		Cost	150	150	300	100	100	200	100	200	300	50	75	75	200	1,000	Rank
ASPR	MISSION SUPPORT CENTER (HHS COOP OPERATIONS)	\$ 600,000	150	150	300	75	75	150	100	200	300	50	75	75	200	950	1
FDA	NEW CAMPUS CHILLER PLANT (JLC)	\$ 36,490,000	100	100	200	75	100	175	75	200	275	50	75	75	200	850	2
OIG	FACILITIES MANAGEMENT INITIATIVE	\$ 9,850,000	100	100	200	50	75	125	100	200	300	50	75	75	200	825	3
FDA	FDA DISASTER RECOVERY CENTER (JLC)	\$ 20,000,000	150	100	250	75	100	175	50	100	150	50	75	50	175	750	4
FDA	FDA COOP DEVOLUTION FACILITY COOP (JLC)	\$ 4,000,000	150	100	250	100	100	200	40	75	115	50	75	50	175	740	5
IHS	SELLS HEALTH CENTER REPLACEMENT FACILITY	\$ 40,000,000	150	100	250	75	60	135	75	100	175	50	75	50	175	735	6
NIH	REPLACE COOLING TOWERS 18, 19 CHILLERS 17,18 19	\$ 40,000,000	100	150	250	50	100	150	50	80	130	50	75	75	200	730	7
FDA	BUILDING 5D PATHOLOGY FIT OUT (JLC)	\$ 18,700,000	100	100	200	50	50	100	75	150	225	50	100	50	200	725	8
ONC	OFFICE SPACE RENOVATIONS	\$ 500,000	50	50	100	50	50	100	100	200	300	50	75	75	200	700	9
FDA	FOOD PROCESSING SCIENCE AND TECHNOLOGY (IL)	\$ 62,600,000	100	100	200	75	75	150	65	100	165	50	75	50	175	690	10
NIH	ELECTRICAL POWER RELIABILITY, CLINICAL CENTER	\$ 2,350,000	50	50	100	75	50	125	60	195	255	50	75	75	200	680	11
IHS	FORT DUCHESNE HEALTH CENTER MODERNIZATION	\$ 3,500,000	100	100	200	75	75	150	75	100	175	0	75	75	150	675	12
IHS	CHEMAWA INDIAN HEALTH CENTER	\$ 5,800,000	100	100	200	75	75	150	50	100	150	0	75	75	150	650	13
IHS	YAKAMA DENTAL BUILDING	\$ 9,590,000	100	100	200	75	75	150	50	90	140	0	75	75	150	640	14
NIH	NIAID SUPPORT BUILDING (RML)	\$ 60,113,000	50	75	125	50	25	75	50	200	250	50	75	50	175	625	15
NIH	CONVERT BUILDINGS 102, POOLESVILLE, MD	\$ 1,016,000	75	75	150	50	50	100	50	100	150	50	75	75	200	600	16
NIH	CLINICAL AND COMPUTATIONAL SCIENCE BUILDING (RTP)	\$157,215,000	100	75	175	75	50	125	75	50	125	50	50	50	150	575	17
FDA	DENVER LABORATORY REPLACEMENT	\$ 78,200,000	50	75	125	50	50	100	75	75	150	50	75	50	175	550	18
IHS	GENERATORS FOR CALIFORNIA AREA TRIBAL HEALTH PROGRAMS	\$ 10,000,000	50	100	150	75	75	150	25	50	75	0	75	75	150	525	19
FDA	HVAC DEFICIENCIES PACIFIC NORTHWEST LAB (WA)	\$ 9,600,000	50	75	125	25	50	75	50	75	125	50	75	50	175	500	20
IHS	WHITE EARTH HEALTH CENTER	\$ 10,000,000	50	50	100	75	75	150	40	40	80	0	75	75	150	480	21
IHS	NATIONWIDE QUARTERS NEW AND REPLACEMENT	\$ 75,000,000	50	100	150	75	75	150	50	50	100	0	0	0	0	400	22



## LIFE CYCLE COST ESTIMATE(S) METHODOLOGY

The Life Cycle Cost Estimate(s) (LCCE(s)) methodology encompasses the planning, acquisition and construction, operations and maintenance (and repair), modernization, and disposal phases of each project. These phases have different methods of estimating based on their sequence in the life of the project, and the individual phase estimates are aggregated to arrive at the complete project LCCE. It is important to note that the LCCE methodology is not industry standard but tailored to HHS based on some relevant portfolio characteristics and data available to make informed projections.

The HHS portfolio is geographically dispersed and while geo-based estimating would provide the most accurate cost estimates, it is impractical to generate high level LCCE for projects at the geographical level given the size of and dispersity of the HHS Real Property Portfolio. Therefore, it is deemed reasonable that the LCCE methodology is based on Division and real property type given that there is a higher level of homogeneity and other similarities between projects and property portfolios at the Division level rather than Department level.

Additionally, the LCCE methodology leverages data captured and reported into the HHS ARIS database; said data is transformed to a \$/USF basis and applied to each project based on the most similar or reasonably applicable real property type (not project type) to the project being executed; this is due to the fact that the data available at the project level, gathered and developed by the Divisions, is too granular and heterogeneous and therefore of impractical use at the Department level.

The estimating of the planning, acquisition and construction phases for capital improvement projects is captured and reported by the Divisions during the formulation of the FPAA, which requires a detailed cost estimate be developed, capturing the entire project costs from planning through activation. These cost estimates are then used by the Divisions to recommend projects for review, approval, funding and execution.

The costs of the operations and maintenance (O&M) phase of the individual real properties (not projects) are captured and reported into the ARIS database on a quarterly basis. The O&M costs are aggregated by Division and real property type and calculated on a \$/USF basis for inclusion into the LCCE. The O&M costs are projected 40 years out,<sup>27</sup> and the projected yearly cash flows are adjusted for inflation and aggregated; the resulting cumulative \$/USF is then applied to each project as described above.

The modernization phase costs are estimated based on two major infusions of capital throughout the life of the real property, at the 1/3 and 2/3 stages of life, approximately every 13.5 years. The historical and estimated future expenditures are captured and reported into the ARIS database on a quarterly basis. These expenditures are also aggregated by Division and real property type and calculated on a \$/USF basis for inclusion into the LCCE. The historical expenditures are projected as future values adjusted for inflation to the 1/3 and 2/3 stages of life and aggregated; the resulting cumulative \$/USF is then applied to each project as described above. The estimated future expenditures reported into the ARIS database are used as a "barometer" to ensure the projections are reasonable but are not used in any of the calculations.

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<sup>27</sup> The 40-year asset lifetime (as opposed to the industry accepted 30 years) is selected based on the Key Performance Indicator (KPI) of the average age of all Owned Buildings in the HHS portfolio.

The disposal phase costs are projected in a similar fashion as the modernization costs using the same inflation and expected asset lifetime, using current benchmark costs between \$40-\$60/USF. These future value projections are then applied to the projects based on reasonable geographical considerations, given that more remote geographical areas command higher disposal costs than urban areas would.

An example of the transformed and calculated \$/USF factors, and projected portions used to inform the projects LCCE is provided below showcasing the CDC portfolio for reference; it is important to note that each OPDIV and real property type has its own applicable factors. The LCCE calculations are shown only for the Capital Improvement Projects – FY 2022 prioritized and selected to receive funding in a future section of this document.

1. Real Property Type	35		Yearly Inflation	2%	<<< FY20 Inflation 2.1% to 2.3% (2% accepted for calcs)		
7a. Status Indicator	(Multiple Items)		Investment Timeframe	40	<<< Based on current Average Age of Owned Buildings		

OPDIV and Property Type	-USF-	Owned - O/M&R Cost	Owned - O/M&R \$/USF	Cumulative Owned - O/M&R \$/USF	Leased - O/M&R Cost	Leased - O/M&R \$/USF	Cumulative Leased - O/M&R \$/USF
<b>CDC</b>	<b>4,776,586</b>	<b>\$ 156,444,822</b>	<b>\$ 32.75</b>	<b>\$ 2,017.88</b>	<b>\$ 7,599,864</b>	<b>\$ 1.59</b>	<b>\$ 98.03</b>
Childcare Center	27,000	\$ -	\$ -		\$ -	\$ -	
Dormitories	1,300	\$ 755	\$ 0.58	\$ 35.78	\$ -	\$ -	
Facility Security	35,727	\$ 629,738	\$ 17.63	\$ 1,085.97	\$ -	\$ -	
Industrial	169,308	\$ 2,555,439	\$ 15.09	\$ 929.91	\$ -	\$ -	
Institutional	191,233	\$ 3,378,942	\$ 17.67	\$ 1,088.60	\$ -	\$ -	
Laboratories	1,890,669	\$ 84,493,167	\$ 44.69	\$ 2,753.32	\$ -	\$ -	
Office	2,156,556	\$ 61,287,691	\$ 28.42	\$ 1,750.91	\$ 6,806,474	\$ 3.16	\$ 194.45
Other	55,926	\$ 1,096,443	\$ 19.61	\$ 1,207.88	\$ -	\$ -	
Service	35,092	\$ 352,651	\$ 10.05	\$ 619.14	\$ -	\$ -	
Warehouse	213,775	\$ 2,649,996	\$ 12.40	\$ 763.73	\$ 793,390	\$ 3.71	\$ 228.66

1. Real Property Type	35		Current Disposal \$/USF	FV Disposal \$/USF
7a. Status Indicator	(Multiple Items)		\$ 40.00	\$ 88.32
			\$ 50.00	\$ 110.40
			\$ 60.00	\$ 132.48

OPDIV and Property Type	-USF-	Historical Expenditures \$/USF	Modernization FV Stage 1 - \$/USF	Modernization FV Stage 2 - \$/USF	Modernization FV Aggregate \$/USF	Est. Future Expenditures \$/USF
<b>CDC</b>	<b>4,776,586</b>	<b>\$ 16.55</b>	<b>\$ 21.56</b>	<b>\$ 28.07</b>	<b>\$ 49.63</b>	<b>\$ 82.29</b>
Childcare Center	27,000	\$ -			\$ 7.97	
Dormitories	1,300	\$ -			\$ 116.34	
Facility Security	35,727	\$ 13.29	\$ 17.31	\$ 22.54	\$ 39.85	\$ 28.91
Industrial	169,308	\$ 70.89	\$ 92.31	\$ 120.20	\$ 212.51	\$ 285.45
Institutional	191,233	\$ 1.58	\$ 2.05	\$ 2.67	\$ 4.72	\$ 42.06
Laboratories	1,890,669	\$ 23.60	\$ 30.73	\$ 40.02	\$ 70.76	\$ 138.83
Office	2,156,556	\$ 9.51	\$ 12.38	\$ 16.13	\$ 28.51	\$ 25.65
Other	55,926	\$ 6.25	\$ 8.13	\$ 10.59	\$ 18.72	\$ 132.33
Service	35,092	\$ 3.97	\$ 5.16	\$ 6.72	\$ 11.89	\$ 143.92
Warehouse	213,775	\$ 3.16	\$ 4.12	\$ 5.36	\$ 9.47	\$ 23.54

FIGURE 7. LCCE FACTORS AND PROJECTIONS SAMPLE



## CAPITAL PLANNING GAPS AND OPPORTUNITIES

### COORDINATION BETWEEN LEADERSHIP TEAMS

There is an ongoing effort at the Department to improve coordination between the project, policy and budget teams who are responsible for leading the capital planning efforts.

Improved integration between teams will result in better collaboration and streamlined decision making. Short term goals include improved budget guidance alignment, reduction of forms, and broader alignment with GSA and other federal agencies real property capital planning practices.

### AUTONOMY OF DIVISIONS

The Divisions have maximum delegated responsibility and limited delegated authority per Department policy. At the same time, the sheer size of some Divisions results in the crossing of boundaries outside of the allotted grounds, which consequently impacts the capital planning effort at the Division and Department levels. These excursions appear systemic and ground in culturally accepted behavior and are in-need of clarification by the Divisions, understanding by the Department, and agreement on common grounds of operation going forward.

### FUNDING SOURCES

Capital projects and sustainment programs are funded from multiple sources. These include Building and Facilities (B&F) fund, the Non-Recurring Expenses (NEF) fund, and external sources. Examples of external sources are fees paid by industry for services rendered by some Divisions, royalties from licensing proprietary information, gifts rendered by donors, rent payments from internal stakeholders, special appropriations and other non-conventional funding streams available. The results from these varied funding sources materialize in diverging priorities from the prescribed Department priorities, which impact the capital planning efforts.

### FUNDING ALLOCATION

In addition to the impact from varied funding sources, a recurring gap identified is the redirection of funding allocated for sustainment into capital improvement projects, which results in the further physical degradation of the real property portfolio. Competing interests of new initiatives over existing needs have consistently resulted in the neglect of the existing portfolio. This is reflected in the poor overall condition of the Real Property Portfolio across many metrics.

### FUNDING FOR TENANT IMPROVEMENTS

Costs for tenant improvements for leased locations often exceed the budget thresholds that have been established for capital improvement projects. HHS will consider implementing policy that would require the SRPO to review planned tenant improvements over \$1M and the CIRB to approve planned tenant improvements over \$10M.

### DISPERSE PORTFOLIO

The HHS Real Property Portfolio consists of 4,162 properties scattered across the U.S., the District of Columbia and Puerto Rico; most notably, IHS and FDA sub-portfolios are



substantially located in remote access areas of the country. This results in a capital planning gap of a large scale, as the individual needs of all projects and properties can be extremely varied at any given time. Such a portfolio is not always able to capitalize in economies of scale and is negatively impacted when attempting to properly plan and attend to the different needs of the Divisions.

## STAKEHOLDERS NOT PARTNERS

It is known that internal clients of the Divisions tend to behave not as partners of the facilities staff, thus creating the unwarranted need of “satisfying stakeholders” by the facilities staff, which can result in additional burden to the facilities staff and unnecessary frictions with the Department. The perceived distance of the Department in relation to the stakeholders as it relates to real property exacerbates the perceived lack of empathy, aggravating the disconnect between multiple parties.

A leadership alignment and fostering of partnerships between the stakeholders and the facilities staff will promote communication across the entire organization, resulting in higher understanding of the needs of both parties, and increased collaboration towards the achievement of shared goals.

## ARIS DATABASE

The ARIS is underleveraged and not consistently used as a data-driven decision-making tool, but rather as a must-do quarterly reporting requirement, which is not always adequately populated, and afterwards not fully maintained, nor consistently curated, nor regularly audited by the Department.

Data calls take place regularly between HHS and the Divisions, and while they are answered, it has been found that the data relayed is not always of high quality or accuracy, subject to inconsistencies and mistakes, and may not all be up to date. Furthermore, the ARIS falls short on providing automated reports. This necessitates personnel to mine through the data to produce the reports, which can result in inconsistencies throughout the recurrent reports given the individual staff member interpretation of the reporting requirements, and/or of the data used to generate them.

A continuous effort is required to train the Divisions and the Department to understand how to properly populate the ARIS database. Also, how to audit the data for quality and accuracy, and more importantly, instill in the data stewards why the data is needed, why it is important, and how it is ultimately used for data-driven decision-making, audits, plans and projections at the Department.

## INCOMPLETE LIFE CYCLE COST ESTIMATES

Complete, cradle-to-grave, Life Cycle Cost Estimates are not regularly incorporated into project planning. Cost estimates generally stop at the request for funding for the short and medium-term planning for most projects, while the costs to continue the proper operations and maintenance, adequate repair, recapitalization and disposal efforts are reactionary and sorted out in the short-term plans as the needs arise, negatively impacting said plans. Economic models for full life-cycle cost estimation of the projects and real properties are not available from the Divisions, nor have they been actively required by the Department.

The LCCE methodology presented in this document is developed as an effort to start the practice of incorporating the full LCCE of the various initiatives into regular practice. Also, to



better understand the impact each of the initiatives have over the long-term operations of the Divisions and the proper planning for funding and support from the Department.

## PERFORMANCE GOALS AND METRICS

<b>Key Performance Indicators - CY 2020</b>	
<b>Indicators</b>	<b>Value</b>
"Reduce the Footprint" Portfolio (M USF)	17.20
"Reduce the Footprint" Portfolio as a Percent of Baseline	89.1%
Average Building Age (Years) - Direct Owned	40.87
Percent of Owned Portfolio USF with Facility Condition Index of 90 or greater	52.5%
Percent of Owned Portfolio Buildings with Facility Condition Index of 90 or greater	64.9%
USF per Person - Direct Owned Office Space	140
USF per Person - Direct Leased Office Space	311
USF per Person - Occupancy Agreement Office Space	227
Rent per USF – Direct Leased Office	\$ 20.24
Rent per USF – Direct Leased Warehouse	\$ 4.12
Rent per USF – Occupancy Agreement Office	\$ 35.61
Rent per USF – Occupancy Agreement Warehouse	\$ 11.01
Operations and Maintenance Cost Per USF – Direct Owned Office	\$ 22.41
Operations and Maintenance Cost Per USF – Direct Owned Warehouse	\$ 5.36
Historical Expenditures - Direct Owned Portfolio (\$M)	\$ 355.94
Estimated Future Expenditures - Direct Owned Portfolio (\$M)	\$ 1,188.84
Expiring Leases - 2020	294
Holdover Leases - Expiration 2021 and Beyond	845

## LIST OF PROJECTS

25 capital improvement projects totaling \$2,368.68 million and four sustainment programs totaling \$614.16 million, were submitted by the Divisions to the Department for consideration in formulating the fiscal year 2022 budget request:

### SUSTAINMENT PROGRAMS – FY 2022

Sustainment Programs - FY22			
Program Name	OPDIV Priority Ranking	Gap Eliminated	Funding Requested (\$M)
<b>Centers for Disease Control and Prevention (CDC)</b>			
Sustainment Program	N/A	Eliminates Backlog of Maintenance and Repair, provides critical mission support, improves condition index of buildings	\$ 45.00
<b>Food and Drug Administration (FDA)</b>			
Sustainment Program	N/A	Eliminates Backlog of Maintenance and Repair, provides critical mission support, improves condition index of buildings	\$ 15.49
<b>Indian Health Services (IHS)</b>			
Sustainment Program	N/A	Eliminates Backlog of Maintenance and Repair, provides critical mission support, improves condition index of buildings	\$ 450.00
<b>National Institutes of Health (NIH)</b>			
Sustainment Program	N/A	Eliminates Backlog of Maintenance and Repair, provides critical mission support, improves condition index of buildings	\$ 103.66
<b>Total Funding Request</b>			<b>\$ 614.15</b>



## CAPITAL IMPROVEMENT PROJECTS – FY 2022

Capital Improvement Projects - FY22				
Project Name	OPDIV Priority Ranking	Gap Eliminated	Funding Requested (\$M)	Funding Expected or Approved, (\$M)
Centers for Disease Control and Prevention (CDC)				
CDC (No new projects for FY22)	NA	NA	\$ -	\$ -
<b>Total CDC</b>			<b>\$ -</b>	<b>\$ -</b>

## Capital Improvement Projects - FY22

Project Name	OPDIV Priority Ranking	Gap Eliminated	Funding Requested (\$M)	Funding Expected or Approved, (\$M)
<b>Food and Drug Administration (FDA)</b>				
New Campus Chiller Plant, Jefferson Labs Complex (JLC)	1	Ensures campus reliability in accordance with JLC master plan	\$ 36.49	\$ 35.00
Denver Laboratory Replacement (Denver Federal Center, Lakewood, CO)	2	Replaces functionally and operationally obsolete building that compromises vital functions with state-of-the-art federally owned lab building	\$ 78.20	\$ -
FDA Disaster Recovery Center, JLC	3	Provides data recovery and data center consolidation	\$ 20.00	\$ -
Building 5D Pathology Fit Out, JCL	4	Consolidates pathology operations in accordance with JLC master plan	\$ 18.70	\$ -
FDA COOP/Devolution Facility, JLC	5	Provides SCIF for COOP/devolution activities in event of disaster	\$ 4.00	\$ -
Food Processing Science and Technology Lab Replacement (Bedford Park, IL)	6	Replaces aged lab with new state-of-the-art lab to enhance CFSAN's food safety programs	\$ 62.60	\$ -
Pacific Northwest Lab (Bothell, WA) - Correct HVAC Deficiencies	7	Renovates antiquated infrastructure to ensure health and safety of lab staff until lab can be fully renovated/replaced	\$ 9.60	\$ -
<b>Total FDA</b>			<b>\$ 229.59</b>	<b>\$ 35.00</b>



## Capital Improvement Projects - FY22

Project Name	OPDIV Priority Ranking	Gap Eliminated	Funding Requested (\$M)	Funding Expected or Approved, (\$M)
<b>Indian Health Services (IHS)</b>				
Phoenix Indian Medical Center (IMC), AZ, Health Care Systems, Central Hospital and ACC		These funds will be used to design the new Phoenix Indian Medical Center campus, a new Central facility that will be a major resource to the satellite facilities. The Central facility will be designed and equipped with full telemedicine support and visiting professionals to provide specialty care services, and will continue to serve as a referral hospital for specialty consultation and procedures	\$ 45.00	\$ 86.00
White River Hospital, AZ		These funds will be used to provide infrastructure and begin construction of the proposed replacement hospital. It will serve a projected user population of 36,113 providing 67,000 primary care provider visits and 101,200 outpatient visits annually. It is estimated 144 staff quarters will be required for health staff.	\$ 100.00	
Gallup, NM Hospital		These funds will be used to design the replacement Gallup Indian Medical Center that will provide comprehensive inpatient, ambulatory, behavioral, and preventive health services for the Gallup Service Unit. Specialty Care and Inpatient care services will provide support other Navajo Area IHS service units	\$ 35.00	

## Capital Improvement Projects - FY22

Project Name	OPDIV Priority Ranking	Gap Eliminated	Funding Requested (\$M)	Funding Expected or Awarded, (\$M)
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### Indian Health Services (IHS)

Broadway Gap, AZ		These funds will be used to complete construction of the 82 staff quarters located in The Gap, AZ. The Health Center will serve a projected user population of 4,646 generating 18,458 primary care provider visits annually. The facility will provide an expanded outpatient and community health department, and a full array of ancillary and support services.	\$ 44.50	Shared \$86M from above
Albuquerque Health Care System, NM		These funds will be used to complete construction of the health center located in central Albuquerque, NM. The Health Center will serve a projected user population of 15,500 generating 59,300 primary care provider visits annually. The facility will provide an expanded outpatient and community health department, and a full array of ancillary and support services.	\$ 89.40	
Sells, AZ		These funds will be used to provide infrastructure and begin construction of the proposed replacement Facility. The facility will provide an expanded outpatient and community health department, and a full array of ancillary and support services	\$ 100.00	



## Capital Improvement Projects - FY22

Project Name	OPDIV Priority Ranking	Gap Eliminated	Funding Requested (\$M)	Funding Expected or Approved, (\$M)
<b>Indian Health Services (IHS)</b>				
Staff Quarters		Many of the 2,700 quarters across the IHS health delivery system are more than 40 years old and in need of major renovation or total replacement. Additionally, in a number of locations the amount of housing units is insufficient. The unmet need for staff quarters is over 800 units. As healthcare facilities expand their space to meet the need for health care, the need for healthcare providers increases. Without an increase in housing units providers cannot be recruited. The identified unmet need of housing units in isolated, remote locations is a significant barrier to the recruitment and retention of quality healthcare professionals across Indian Country. The amount distributed will be based on a priority	\$ 20.00	Shared \$86M from above
Small Ambulatory		This funding allows the IHS to request applications from interested Tribes. Projects will be selected from applications meeting the program requirements as set forth in IHCIA section 305. Funds will be provided for the construction, expansion or modernization of non-IHS owned small Tribal ambulatory health care facilities located apart from a hospital. At this level of funding, the HCFC program could assist up to 10 communities to advance their access to health care.	\$ 100.00	\$ -
Ambulatory Facility Program (New Initiative)			\$ 25.00	\$ 25.00
Facilities for Urban Indian Organization (New Initiative)			\$ 25.00	\$ 25.00
<b>Total IHS</b>			<b>\$ 583.90</b>	<b>\$ 136.00</b>

## Capital Improvement Projects - FY22

Project Name	OPDIV Priority Ranking	Gap Eliminated	Funding Requested (\$M)	Funding Expected or Approved, (\$M)
<b>National Institutes of Health (NIH)</b>				
N-15-009 Surgery, Radiology and Lab Medicine Building (SRLM)	1	-- CI of 72.04 and \$142.6M BMAR -- Functional space and circulation routes inadequacies/inefficiencies; -- Facility limitations restricting the flexibility/adaptability to address growth and change; -- Deficient and unreliable infrastructure systems are (i.e. normal and emergency power, communication systems, HVAC) -- Structural problems / unacceptable vibration levels in some areas of the building.	\$ 849.52	\$ -
N-17-001 Replace Clinical Center Patient and Visitor Parking (MLP-12)	2	CI of 64.70 and \$34.849 BMAR (Based on comparison to ACRF Parking Garage) -- The ACRF parking facility is the primary parking structure for the Clinical Center Complex. A 2012 report determined \$27M would have to be expended in order to repair the 42-year old ACRF parking facility. This investment in a facility that is already past its useful life could cause severe disruption to hospital operations including surgery, would perpetuate a security risk of parking beneath the hospital and would require the displacement of parking over several years to complete. -- Currently there is a shortfall of surface parking on the Bethesda campus due to various construction projects.	\$ 41.66	\$ -



## Capital Improvement Projects - FY22

Project Name	OPDIV Priority Ranking	Gap Eliminated	Funding Requested (\$M)	Funding Expected or Approved, (\$M)
<b>National Institutes of Health (NIH)</b>				
N-16-010 Clinical and Computational Science Building, RTP	3	-- CI of 88.66 and \$1.621M BMAR -- The Clinical Research Unit (CRU) is housed in a modular facility; as laboratory and clinical processes have evolved, the existing modular facilities have become inadequate to efficiently handle new scientific techniques and clinical procedures. -- Appropriate space for computational and data science is mission-critical. NIEHS does not have an technology-centered "dry" laboratory facility to address the NIH Director's priority on advancing computational and data science.	\$ 173.18	\$ -
N-16-009 ORS/ORF NIAID Support Buildings RML	4	-- CI ranging from 61 to 84 and \$.637M BMAR -- The facilities housing the critical support functions of these programs have remained unchanged for many years, while the scientific structure being supported continues to expand. -- Additional staff have been hired without adequate facilities available to house and support them. -- The current deficient facilities negatively affect the ability to provide the central support functions and consequently negatively affect the scientific mission of NIH at RML.	\$ 79.00	\$ 40.65

## Capital Improvement Projects - FY22

Project Name	OPDIV Priority Ranking	Gap Eliminated	Funding Requested (\$M)	Funding Expected or Approved, (\$M)
<b>National Institutes of Health (NIH)</b>				
N-15-011 Electrical Power Reliability for the CCC	5	<p>CI of 74.21 and \$55.347 BMAR</p> <p>-- Building 10 is currently serviced from a 60+ year old electrical distribution system of wiring and components. Reliability of the electrical system is compromised by the continued use of this old installation.</p> <p>-- The distributed electrical closets throughout Building 10 are inadequate in size and capacity to house the ever-growing power distribution requirement of the current research and clinical programs and do not meet current National Electrical codes.</p> <p>-- The ACRF electrical vaults are currently operated in a deviated state from the original design as the transfer control systems have been compromised and have become unreliable to meet Joint Commission compliance.</p> <p>-- Space constraints in the existing vaults has limited the ability to expand electrical switchgear necessary to provide additional power distribution in support of these increasing demands.</p>	\$ 83.31	\$ -



## Capital Improvement Projects - FY22

Project Name	OPDIV Priority Ranking	Gap Eliminated	Funding Requested (\$M)	Funding Expected or Approved, (\$M)
<b>National Institutes of Health (NIH)</b>				
N-19-011 Replace Cooling Towers 18,19 and Chillers 17,18,19	6	<p>-- As of 1/1/20 chemical manufacturers will no longer be able to produce or import R-22 refrigerant; the Building 11 Chillers 17, 18 and 19 on the NIH Bethesda campus use R-22 refrigerant. This supply shortage impacts: normal operation of HVAC systems, chiller maintenance and repairs, and refurbishment programs.</p> <p>-- The existing Cooling Towers 18 and 19 that align with the chillers date back to the 1994 and are beyond their life span and do not have the capacity to meet the current and future cooling demands of the campus.</p> <p>-- The electrical equipment (i.e. transformers, switchgear, MCCs, panels boards, etc.) associated with the existing Chillers 17, 18 and 19 is outdated and requires replacement to align with the new proposed chillers.</p>	\$ 239.78	\$ -
N-20-008 Repair Parking Garages, Bethesda	7	<p>-- CI ranging from 64.89 to 97.99 and \$4.359 BMAR for all 4 garages.</p> <p>-- The MLP structures are deteriorating due to lack of maintenance, poor drainage, chloride-induced corrosion, salt &amp; water infiltration, concrete spall / delamination and settlement issues.</p> <p>-- Recently discovered pieces of falling delaminated concrete from the underside of garage deck slabs are posing serious safety risks to garage users, including visitors, patients and NIH staff &amp; contractors.</p>	\$ 36.78	\$ -

## Capital Improvement Projects - FY22

Project Name	OPDIV Priority Ranking	Gap Eliminated	Funding Requested (\$M)	Funding Expected or Approved, (\$M)
<b>National Institutes of Health (NIH)</b>				
NIAID COVID-19 Countermeasure Development Facility (USF 19,985) (Location TBD)	8	Lack of space for COVID-19 vaccine research	\$ 25.98	\$ -
NCATS COVID-19 Lab Space (USF 19,985) (Location TBD)	9	Lack of space for COVID-19 vaccine research	\$ 25.98	\$ -
<b>Total NIH</b>			<b>\$ 1,555.19</b>	<b>\$ 40.65</b>
<b>Total Funding Request vs Award</b>				
			<b>\$ 2,368.68</b>	<b>\$ 211.65</b>



## CAPITAL IMPROVEMENT PROJECTS - FY 2022 - LIFE CYCLE COST ESTIMATE

HHS Capital Improvement Projects - FY22 - Life Cycle Cost Estimates (LCCE)													
Project Name	LCCE Real Property Type	Estimated USF	Planning and Activation, \$	O&M \$/USF	O&M, \$	Modernization \$/USF	Modernization, \$	Disposal \$/USF	Disposal \$	LCCE	LCCE / P&A Ratio		
New Campus Chiller Plant, Jefferson Labs Complex (JLC)	Laboratory	16,900	\$ 36,490,000	\$ 874.61	\$ 14,780,909	\$ 68.25	\$ 1,153,425	\$ 88.32	\$ 1,492,608	\$ 53,916,942	1.48		
<b>Total FDA</b>		<b>16,900</b>	<b>\$ 36,490,000</b>		<b>\$ 14,780,909</b>		<b>\$ 1,153,425</b>		<b>\$ 1,492,608</b>	<b>\$ 53,916,942</b>			
Phoenix Indian Medical Center (IMC), AZ, Health Care Systems, Central Hospital and ACC	Hospital	112,856	\$ 45,000,000	\$ 20.60	\$ 2,324,832	\$ 23.49	\$ 2,650,986	\$ 88.32	\$ 9,967,437	\$ 59,943,256	1.33		
White River Hospital, AZ	Hospital	112,856	\$ 100,000,000	\$ 20.60	\$ 2,324,832	\$ 23.49	\$ 2,650,986	\$ 132.48	\$ 14,951,156	\$ 119,926,974	1.20		
Gallup, NM Hospital	Hospital	112,856	\$ 35,000,000	\$ 20.60	\$ 2,324,832	\$ 23.49	\$ 2,650,986	\$ 110.40	\$ 12,459,296	\$ 52,435,115	1.50		
Broadway Gap, AZ	Hospital	112,856	\$ 44,500,000	\$ 20.60	\$ 2,324,832	\$ 23.49	\$ 2,650,986	\$ 132.48	\$ 14,951,156	\$ 64,426,974	1.45		

## HHS Capital Improvement Projects - FY22 - Life Cycle Cost Estimates (LCCE)

Project Name	LCCE Real Property Type	Estimated USF	Planning and Activation, \$	O&M \$/USF	O&M, \$	Modernization on \$/USF	Modernization, \$	Disposal \$/USF	Disposal \$	LCCE	LCCE / P&A Ratio
Albuquerque Health Care System, NM	Outpatient Healthcare Facility	13,049	\$ 89,400,000	\$ 4.69	\$ 61,200	\$ 23.49	\$ 306,524	\$ 88.32	\$ 1,152,498	\$ 90,920,222	1.02
Sells, AZ	Outpatient Healthcare Facility	13,049	\$ 100,000,000	\$ 4.69	\$ 61,200	\$ 23.49	\$ 306,524	\$ 110.40	\$ 1,440,622	\$ 101,808,346	1.02
Staff Quarters	Family Housing	2,270	\$ 20,000,000	\$ 105.70	\$ 239,949	\$ 0.21	\$ 477	\$ 88.32	\$ 200,495	\$ 20,440,920	1.02
<b>Total IHS</b>		<b>\$ -</b>	<b>479,792</b>	<b>\$ 433,900,000</b>		<b>\$ 9,661,680</b>	<b>\$ 11,217,469</b>		<b>\$ 55,122,660</b>	<b>\$ 509,901,808</b>	
N-16-009 ORS/ORF NIAID Support Buildings RML	Laboratories	46,800	\$ 79,000,000	\$ 2,290.93	\$ 107,215,524	\$ 106.08	\$ 4,964,544	\$ 132.48	\$ 6,200,064	\$ 197,380,132	2.50
<b>Total NIH</b>		<b>\$ -</b>	<b>46,800</b>	<b>\$ 79,000,000</b>		<b>\$ 107,215,524</b>	<b>\$ 4,964,544</b>		<b>\$ 6,200,064</b>	<b>\$ 197,380,132</b>	
<b>Total LCCE for Capital Improvement Projects - FY22</b>		<b>\$ -</b>	<b>543,492</b>	<b>\$ 549,390,000</b>		<b>\$ 131,658,113</b>	<b>\$ 17,335,438</b>		<b>\$ 62,815,332</b>	<b>\$ 761,198,882</b>	



## CAPITAL IMPROVEMENT PROJECTS – FY 2022 (FY 2019 TO FY 2027)

Capital Improvement Projects - FY22 (FY19 to FY27)																	
PROJECTS \ FY & FUNDING SOURCE	FY19 or prior	FY20 B&F	FY20 NEF	FY21 B&F	FY21 NEF	FY22 B&F	FY22 NEF	FY23 B&F	FY23 NEF	FY24 B&F	FY24 NEF	FY25 B&F	FY25 NEF	FY26 B&F	FY26 NEF	FY27 B&F	FY27 NEF
<b>Centers for Disease Control and Prevention (CDC)</b>																	
C-P20XXXXXX Building 25 Disease X Pandemic Response Laboratory, Roybal Campus <sup>4</sup>												\$ 500.00					
C-P20XXXXXX Building 15 Refurbishment, Roybal Campus <sup>7</sup>											\$ 50.00						
C-P20XXXXXX Building 18 Renovation, Roybal Campus <sup>7</sup>											\$ 50.00				\$ 50.00		
C-P20XXXXXX Building 17 Renovation, Roybal Campus <sup>7</sup>																	
C-P20XXXXXX Laboratory, Infrastructure, and Campus Expansion, Ft. Collins, CO <sup>7</sup>					\$ 250.00												
C-P20XXXXXX Laboratory Expansion, San Juan, PR <sup>7, 8</sup>								\$ 60.00									
C-P20XXXXXX Environmental Health Laboratory Building 112, Chamblee Campus <sup>7, 14</sup>								\$ 300.00									
C-P20161102 Research Support Building 108, Chamblee Campus <sup>7</sup> (NEF Funding)			\$ 225.00														
C-P20XXXXXX Chamblee Expansion Phase I, Property Development <sup>7 15</sup>					\$ 600.00												
C-P20XXXXXX Chamblee Expansion Phase II, Property Development <sup>7 15</sup>													\$ 700.00				
C-P20150618 PHIO Support Facility Building Y, Lawrenceville Campus <sup>7</sup>											\$ 28.80						
C-P20XXXXXX Physical Security Facility Building W, Lawrenceville Campus <sup>7</sup>											\$ 8.10						
C-P20XXXXXX Building V Transshipping Facility, Lawrenceville Campus <sup>7</sup>											\$ 3.10						
C-P20160018- Pittsburgh Building 141 Renovation, Pittsburgh Research Center (PRC) <sup>9</sup> (NEF Funding)					\$ 14.00												
C-P20150737 Pittsburgh Campus Infrastructure and Security Enhancements											\$ 15.20						
C-P20150665 Pittsburgh Consolidated Laboratory, Pittsburgh Research Center (PRC)											\$ 215.50						
C-P20150735 Pittsburgh Transshipping Facility											\$ 11.50						
C-P20150736 Pittsburgh Visitor Center and Secure Entry											\$ 22.40						
C-P2009125 Expansion of Animal Inhalation Facility (HERL), Morgantown, WV <sup>7, 14</sup>											\$ 5.40						
<b>Total CDC</b>	\$ -	\$ -	\$ 225.00	\$ -	\$ 864.00	\$ -	\$ -	\$ 360.00	\$ -	\$ -	\$ 410.00	\$ -	\$ 1,200.00	\$ -	\$ 50.00	\$ -	\$ -

Capital Improvement Projects - FY22 (FY19 to FY27)																	
PROJECTS \ FY & FUNDING SOURCE	FY19 or prior	FY20 B&F	FY20 NEF	FY21 B&F	FY21 NEF	FY22 B&F	FY22 NEF	FY23 B&F	FY23 NEF	FY24 B&F	FY24 NEF	FY25 B&F	FY25 NEF	FY26 B&F	FY26 NEF	FY27 B&F	FY27 NEF
<b>Food and Drug Administration (FDA)</b>																	
Jefferson Labs Complex - Design and Construct New Chiller/Energy Plant	\$ 1.19						\$ 35.30										
Denver Laboratory Replacement (Denver Federal Center, Lakewood, CO)	\$ 36.00						\$ 42.50										
Jefferson Labs Complex - FDA Disaster Recovery Center							\$ 20.00										
Jefferson Labs Complex - Building 5D Pathology Fit Out							\$ 18.70										
Jefferson Labs Complex - FDA COOP/Devolution Facility							\$ 4.00										
Division of Food Processing Science and Technology Lab Replacement (Bedford Park, IL)							\$ 62.60										
San Juan Complex Toro Building Addition	\$ 8.00																
Supplemental Funding for Southeast Lab (Atlanta, GA) Relocation	\$ 17.30		\$ 47.90														
Jefferson Labs Complex - Repairs to Site Infrastructure (Roads, Drainage)	\$ 4.60																
Muirkirk Road Complex (MRC) - Replace Eight Air Handling Units	\$ 5.00																
MRC - Replace Four Emergency Generators & Existing Obsolete Panel Boards			\$ 9.00														
MRC - Correct MOD1 Lab Building Infrastructure Deficiencies				\$ 8.00													
Dauphin Island, AL - Replace Office Trailers with Permanent Office Building	\$ 2.40																
Pacific Southwest Lab (Irvine, CA) - Retaining Wall Construction	\$ 3.30																
Pacific Southwest Lab (Irvine, CA) - Repairs to Surface Parking Areas	\$ 5.00																
Pacific Southwest Lab (Irvine, CA) - Repairs to HVAC and Controls	\$ 6.00																
Pacific Southwest Lab (Irvine, CA) - Renovate Various Labs			\$ 2.40														
Pacific Northwest Lab (Bothell, WA) - Correct HVAC Deficiencies							\$ 9.60										
<b>Total FDA</b>	<b>\$ 88.79</b>	<b>\$ -</b>	<b>\$ 59.30</b>	<b>\$ 8.00</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$192.70</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>



Capital Improvement Projects - FY22 (FY19 to FY27)																	
PROJECTS \ FY & FUNDING SOURCE	FY19 or prior	FY20 B&F	FY20 NEF	FY21 B&F	FY21 NEF	FY22 B&F	FY22 NEF	FY23 B&F	FY23 NEF	FY24 B&F	FY24 NEF	FY25 B&F	FY25 NEF	FY26 B&F	FY26 NEF	FY27 B&F	FY27 NEF
Indian Health Sevices (IHS)																	
<u>Inpatient Facilities</u>																	
PIMC, AZ, Health Care System																	
Central - Hospital & ACC	\$ 2.23	-			-	\$ 70.00		\$ 150.00		\$ 150.00		\$ 301.77					
Whiteriver, AZ, Hospital	\$ 15.00	\$ 10.00			\$ 58.91	\$ 100.00		\$ 100.00		\$ 170.00		-					
Gallup, NM Hospital	\$ 2.00	-			-	\$ 70.00		\$ 200.00		\$ 200.00		\$ 80.00					
<u>Outpatient Facilities</u>																	
Rapid City	\$118.00	\$ 11.80															
Alamo	\$ 51.50	\$ 23.50															
Pueblo Pintado, NM	\$ 97.40	\$ 25.00			-	-		-		-		-					
Bodaway Gap, AZ	\$ 38.38	\$ 42.32			\$ 26.00	\$ 44.50		-		-		-					
Albuquerque Health Care System																	
Albuquerque West, NM	\$ 39.68	\$105.67			-	-		-		-		-					
Albuquerque Central, NM	\$ 0.73	-			\$ 20.00	\$154.00		-		-		-					
Sells, AZ	\$ 15.75	-			-	\$100.00		\$ 109.00		-		-					
<b>Total IHS</b>	<b>\$380.68</b>	<b>\$218.29</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$104.91</b>	<b>\$ -</b>	<b>\$538.50</b>	<b>\$ -</b>	<b>\$ 559.00</b>	<b>\$ -</b>	<b>\$520.00</b>	<b>\$ -</b>	<b>\$381.77</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Capital Improvement Projects - FY22 (FY19 to FY27)																	
PROJECTS \ FY & FUNDING SOURCE	FY19 or prior	FY20 B&F	FY20 NEF	FY21 B&F	FY21 NEF	FY22 B&F	FY22 NEF	FY23 B&F	FY23 NEF	FY24 B&F	FY24 NEF	FY25 B&F	FY25 NEF	FY26 B&F	FY26 NEF	FY27 B&F	FY27 NEF
<b>National Institutes of Health (NIH)</b>																	
<b>FY2011</b>																	
N-11-001 RTP Site Utility Loop		\$ 5.50															
N-11-003 Clinical Center E Wing Renovation Construction		\$ 30.00		\$ 15.00													
<b>FY2015</b>																	
N-15-007 Replace R22 Refrigerant Chillers		\$ 20.00															
N-15-008 Center for Disease Research (CDR)									\$ 600.00								
N-15-009 Surgery, Radiology and Lab Medicine Building (SRLM)		\$ 62.60	\$ 212.40	\$ 229.00		\$ 47.13		\$ 22.50		\$ 32.56		\$ 23.50					
N-15-011 Electrical Power Reliability for the CCC						\$ 23.50		\$ 22.50		\$ 16.00							
<b>FY2016</b>																	
N-16-009 NIAID Support Facilities RML							\$ 60.11										
N-16-010 Clinical and Computational Science Building, RTP							\$ 157.21										
<b>FY2017</b>																	
N-17-001 Replace Clinical Center Patient and Visitor Parking (MLP-12)						\$ 40.05											
N-17-002 NCII Integrated Research Facility												\$ 312.13					
<b>FY2018</b>																	
N-18-004 Electrical Switching Station & Emergency Generators 59/59A		\$ 3.91				\$ 83.21											
N-18-006 Substation 17 Upgrades		\$ 14.68															
N-18-007 Building Automation System Replacement Building 10			\$ 12.60														



Capital Improvement Projects - FY22 (FY19 to FY27)																	
PROJECTS \ FY & FUNDING SOURCE	FY19 or prior	FY20 B&F	FY20 NEF	FY21 B&F	FY21 NEF	FY22 B&F	FY22 NEF	FY23 B&F	FY23 NEF	FY24 B&F	FY24 NEF	FY25 B&F	FY25 NEF	FY26 B&F	FY26 NEF	FY27 B&F	FY27 NEF
National Institutes of Health (NIH)																	
FY2019																	
N-19-002 B38 NLM 1st Floor Renovations (Phase 1)						\$ 8.60											
N-19-003 Building 51 NIH Fire House						\$ 1.87											
N-19-006 Replacement of Direct Buried Steam Pipe Along Convent Dr		\$ 6.85															
N-19-007 Building 31A NINDS 8th Floor Renovation		\$ 8.33															
N-19-008 Bldg. 10 CC Radiopharmacy & Biologics Radiolabeling Facility		\$ 0.71		\$ 21.45		\$ 2.01											
N-19-010 Replace Steam & Chilled Water Lines from Vault 2 to Vault 31C						\$ 23.24											
N-19-011 Replace Cooling Towers 18,19 and Chillers 17,18,19						\$ 40.00		\$ 35.00		\$ 55.00		\$ 55.00		\$ 55.00			
N-19-014 NIHAC - Convert Building 102 A and B Wings, Poolsville						\$ 1.02		\$ 40.12									
FY2020																	
N-20-006 Bulk Fuel Oil Underground Storage Tank		\$ 0.13				\$ 9.36											
N-20-007 B38 NLM 1st Floor Renovations (Phase 2)						\$ 5.63											
N-20-008 Repair Parking Garages, Bethesda						\$ 10.71		\$ 13.36		\$ 10.54							
Repairs & Improvements		\$ 47.29		\$ 34.55		\$103.66		\$266.53		\$285.90		\$321.50		\$345.00		\$400.00	
Total NIH	\$ -	\$ 200.0	\$ 225.0	\$ 300.0	\$ -	\$ 400.0	\$ 217.3	\$ 400.0	\$ 600.0	\$ 400.0	\$ -	\$ 400.0	\$ 312.1	\$ 400.0	\$ -	\$ 400.0	\$ -
Total HHS	\$ 469.5	\$ 418.3	\$ 509.3	\$ 308.0	\$ 968.9	\$ 400.0	\$ 948.5	\$ 760.0	\$ 1,159.0	\$ 400.0	\$ 930.0	\$ 400.0	#####	\$ 400.0	\$ 50.0	\$ 400.0	\$ -

# APPENDIX A: REDUCE THE FOOTPRINT FIVE-YEAR REDUCTION TARGETS

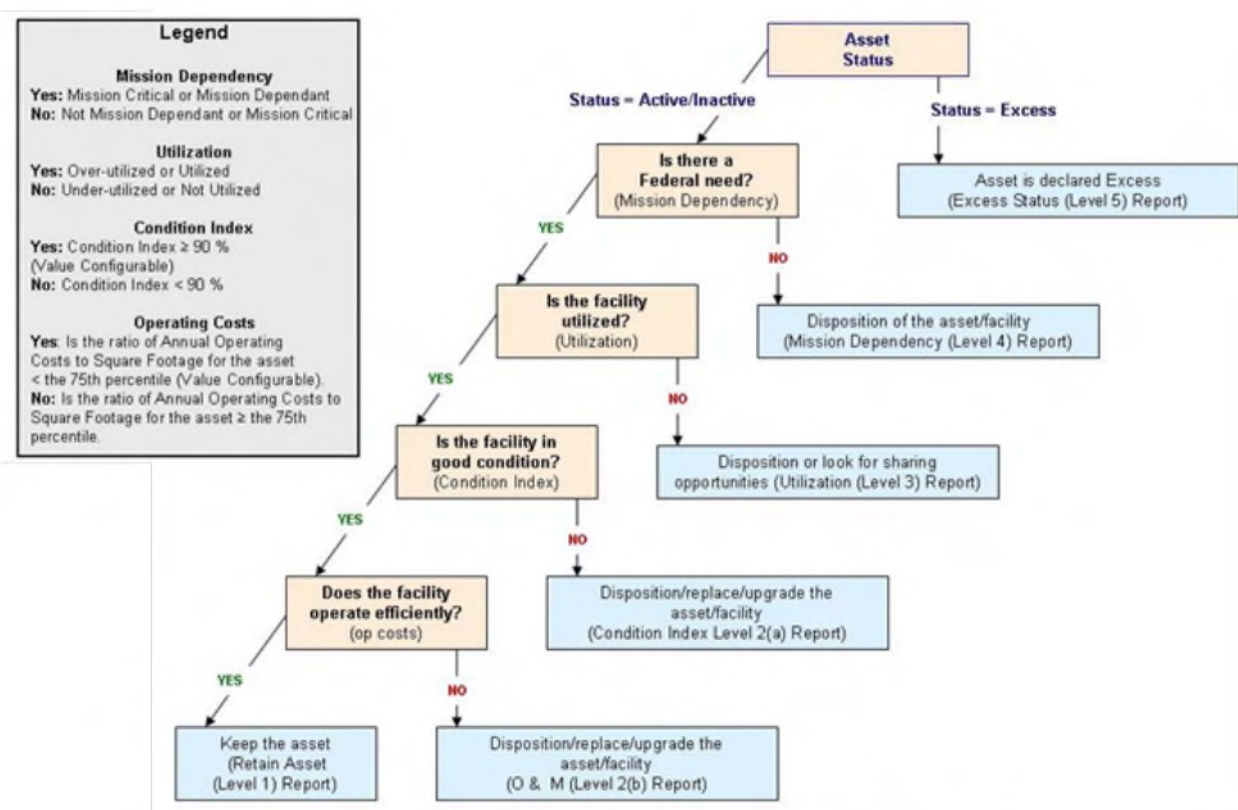
The content of the following appendix is as reported in the HHS Real Property Efficiency Plan FY20-24, issued in September of 2019.

The major challenges to reducing the footprint are:

1. Expanding missions require space. FDA requires additional office space due to increased regulatory responsibilities due to legislation regulating tobacco and medical devices. The Office of Medicare Hearings and Appeals requires approximately 125,000 USF in Atlanta, Albuquerque, Denver, New Orleans and Phoenix to process a continually increasing number of hearings and appeals. As a result, the Department Appeals Board will expand by approximately 15,000 USF in FY 2020 and could expand more in FY 2021. Despite these increases HHS will be able to stay below the FY 2015 baseline by implementing planned office and warehouse space reductions.
2. Consolidation projects require funding for tenant improvements, information technology, and new furniture associated with occupying new space. Projects can be delayed due to limited funding.
3. Geographically dispersed facilities which serve local communities and operations that cannot be consolidated (primarily FDA and IHS).

When evaluating options to reduce its footprint, HHS Divisions employ a decision tree methodology and criteria to identify property disposal candidates. Once the decision is made to dispose of real property via transfer of ownership, HHS utilizes GSA's disposal authority to execute the transfer. After appropriate internal clearances/approvals are received, Divisions are required to report excess real property to HHS PSC/RLO/Real Property Management Service (RPMS) at least 120 calendar days in advance of the date such property will become available for transfer or disposal. RPMS is responsible for reviewing, approving, and screening reports of excess for possible transfer to meet other HHS needs. These reporting and screening requirements are applicable even to Divisions with delegated authority to excess property without HHS approval.





**FIGURE 8. ASSET RETENTION OR DISPOSAL DECISION TREE**

RPMS is also designated as the disposal agent for leases, permits, licenses, easements, and similar real estate interests held by HHS agencies in privately-owned property. This includes Federal government-owned improvements located on the premises except when it is determined by either HHS or GSA that the Federal government's best interests would be served for such disposal to be handled by GSA. HHS currently has one Report of Excess that was accepted in 2017 by GSA for assets in Spartanburg, SC.

There are certain statutory provisions that permit transfer of certain excess real property to Indian tribes without screening of other HHS agencies. They include:

1. The Indian Health Transfer Act, Public Law 83-568 of 1954, Section 4 authorized the properties of Bureau of Indian Affairs (BIA) relating primarily to health matters to be transferred to IHS. Furthermore, a Memorandum of Understanding was entered into in 1961 by the Secretary of the Interior and Secretary of Health, Education, and Welfare, and the Administrator of General Services to cover such transfers of properties between the two Departments involved. Transfers under that authority, which appears in 41 CFR 102-75.1110, do not require any screening of other agencies.
2. Public Law 93-599, approved January 2, 1975, provides for the transfer, without compensation, of certain excess real properties to the Secretary of the Interior to be held in trust status under BIA. Transfers under this authority do not require any screening of other agencies.

3. The IHS, through §105f of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) [25 U.S.C. §450j (f)] permits the use, acquisition, or donation of real estate to a tribe, tribal organization, or urban Indian program pursuant to a self-determination contract or grant agreement. IHS may also acquire excess real property and transfer ownership of property to a tribe.

## STATUS RELATIVE TO REDUCE THE FOOTPRINT BASELINE REQUIREMENT

In fiscal year 2018, HHS reduced its office and warehouse space footprint as follows:

Year	SF Amount
FY17 Year End	19,279,939
FY18 Year End	19,040,470
Total Reduction	239,469

Additionally, HHS achieved an overall reduction from the fiscal year 2015 baseline as follows:

Year	SF Amount
FY15 Baseline	19,287,500
FY18 Year End	19,040,470
SF Below Baseline as of FY17 Year End	247,030

HHS has reduced its inventory of office and warehouse space so that it is now 247,030 SF below the HHS Reduce the Footprint baseline.

## MAINTENANCE OF THE REDUCE THE FOOTPRINT BASELINE

HHS applies space utilization policy in the acquisition of all new leased and owned office and warehouse space. Reductions occur as current space is replaced by new space at the required 170 USF per person on average utilization rate. HHS uses the 5YTL to identify planned office and warehouse reductions and disposals of owned property.

## REDUCTION TARGETS FOR OFFICE AND WAREHOUSE SPACE

HHS uses component 5YTLs to identify annual office and warehouse reduction targets. HHS reviews term expirations for direct leases and space acquired through GSA and then calculates projected space savings by comparing current size and population with projections based on the 170 USF UR. All new space requirements must be approved by the SRPO. Portfolio efficiency opportunities are identified primarily by analyzing the 5YTL.

HHS's total real property reduction target for fiscal years 2020-2024 is 755,567 SF, as shown in the table below. The Department plans to reach this target by disposal of unneeded assets, continued densification of new office and office support space,



consolidation of subcomponent offices at select locations and implementation of a workspace sharing policy that will foster reduction of office space for teleworkers.

The net SF reduction targets are impacted by a few significant office space projects, including the following:

1. There are several reductions to NIH office space in Rockville, MD, totaling 571,064 SF, that were anticipated to occur in FY 2018 but have been delayed. As a result of these delays, HHS's FY 2018 actual office space reduction was 306,311, rather than the 877,792 target included in last year's Real Property Efficiency Plan.
2. FDA is expected to increase office space in FY 2019 due to its expanding missions described in the Overall Agency Building Portfolio section of this document. FDA also has a large prospectus lease in collaboration with GSA for approximately 240,550 SF that is expected to be completed in FY 2023.
3. The Office of Medical Hearings and Appeals is also anticipated to add over 125,000 SF in FY 2020 due to its expanding missions.

#### Domestic Office and Warehouse SF Reduction Targets FY 2020–FY 2024

	<b>FY 2020</b>	<b>FY 2021</b>	<b>FY 2022</b>	<b>FY 2023</b>	<b>FY2024</b>	<b>Totals</b>
<b>Office Target* (Net SF Reduction)</b>	393,176	46,520	282,169	16,195	0	738,060
<b>Warehouse Targets* (Net SF Reduction)</b>	0	650	-5,143	0	0	-4,493
<b>Total</b>	393,176	47,170	277,026	16,195	0	733,567

\*Reductions are reported as a positive value.

Despite the planned FDA and OMHA inventory increases it is anticipated that HHS will continue to stay below the baseline due to ongoing space reduction across the Department.

#### DISPOSAL TARGETS FOR OWNED BUILDINGS

RPMS reviews real property inventory data to identify unused and underutilized assets, and Divisions determine candidates for disposal based on component mission need. Landholding OPDIVs, pursuant to 41 CFR 102-75.990, may demolish buildings with no commercial value, or for which the estimated cost of continued care and handling exceeds the estimated proceeds from its sale, or where the estimated fair market value is less than \$50,000. All other planned demolition projects must be identified and discussed in budget requests to ensure demolition authority is referenced in the proposed buildings and facilities appropriation language. In FY19, HHS disposed of 36 owned buildings, totaling over 163,000 SF, through demolition of federal transfer. Planned disposals are shown below:

#### Disposal Targets for Owned Buildings FY 2020–FY 2024

	FY 2020	FY 2021	FY 2022	FY 2023	FY2024	Totals
Disposal Target* (Net SF Reduction)	626	28,976	0	95,927	0	125,529
Disposal Target* (Number of Buildings)	4	3	0	19	0	26

\*Reductions are reported as a positive value.



## APPENDIX B: CAPITAL PLANNING PROCESS

This appendix describes in summary form the efforts used in generating the Department of Health and Human Services (HHS) Real Property Capital Plan (RPCP) for FY 2022, pursuant to the *Office of Management and Budget (OMB) Management Procedures Memorandum M-20-03, Implementation of Agency-wide Real Property Capital Planning*

The RPCP is crafted using a variety of available documents and references, specific queries directed to and answered by the Divisions, various tables and timelines, and data analysis of the HHS ARIS database. The resources are listed below:

- HHS Strategic Plan 2020 - 2024
- HHS Real Property Efficiency Plan FY 20-24
- HHS Real Property Asset Management Plan – 2013
- HHS Facilities Program Manual – Draft 2021
- HHS 2020 – Facilities Project Prioritization Model
- HHS FY 2022 – Five-Year Timeline
- HHS FY 2022 – Capital Improvement Projects List
- HHS ARIS Database, 11-20-2020 snapshot
- HHS Request for Information: OMB Memo 20-03 Capital Planning
  - FDA Response
  - IHS Response
  - NIH Response
- IHS Real Property Capital Planning Process
- CDC Facilities 20-Year Strategic Plan 2017 – 2037
- NIH Facilities Design Manual - 2018

The various documents and resources listed above are referenced throughout the RPCP as the information contained therein is relevant and its inclusion is tailored towards addressing the major points of the RPCP. These various documents and resources themselves are the results of recurring and ongoing meetings, discussions, commenting, peer review and editing, prior to issuance, delivery, and/or publication. These documents and resources are subject to extensive processes themselves not listed nor described in this appendix, and the RPCP benefits indirectly from these efforts.

Given that some Divisions have their own Division Capital Plans and facilities staff who do the daily decision-making and day-to-day work of managing the Real Property Portfolio through their own internal processes, various example processes are included in the RPCP for reference and illustration of how the aggregate RPCP comes together.

ASFR and PSC officials are responsible for meeting to discuss and approve the RPCP content and its relevance for inclusion; several meetings between the various peers and teams take place resulting in decisions to inform and make edits to the RPCP. At the same time, these discussions have served to validate previous plans and capital decisions made, identify ongoing gaps in capital planning and generate ideas for future improvements to the processes and to the fiscal year 2023 RPCP.

The RPCP process, meetings and discussions have been actively ongoing since January 2020, and will continue through issuance and delivery in January 2021, and beyond.