2013 Annual Report (LGID# 57002)

Special District Annual Report (Per CRS 32-1-207(3)(c) and (d))

Telluride Hospital District d.b.a. Telluride Medical Center

San Miguel County, Colorado

Emergency and Trauma Services
Primary Care/Community Clinic

For Activities Completed by December 31, 2013 and with Information about Prospective Years

Evaluation Committee

Telluride Hospital District Board President

Larry Mallard — Date: 2-19-2014

QA Committee THD Board Member

Carol Kammer — Date: 2/25/2014

Emergency Service Medical Director

Dr. Diana Koelliker — Date: 2/20/14

Primary Care Medical Director

Dr. Sharon Grundy — Date: 2/19/2014

Primary Care Mid-Level

Eric Johnson, NP — Date: 2/19/14

Telluride Medical Center Executive Director

Gordon Reichard, MHA — Date: 2.18.2014

Contents of the Annual Report are as follows:

Attached Exhibits

Exhibit A – Executive Director's Report
Exhibit B – 2013 Financial Annual Report
Exhibit C – 2012 Dalby Wendland Audit Recommendation Letter, 2012 Management Discussion and Analysis and 2D12 Audited Financial Statements
Exhibit D – 2013 Annual Operating Budget
Exhibit E – Mill Levy Actual & Projected
Exhibit F – Assessed Value & Mill Levy History
Exhibit G – TMC Foundation Report
Exhibit H – Emergency Department Report
Exhibit I – Primary Care/Community Clinic Report
Exhibit J – Radiology Department Report
Exhibit K – Pharmacy Report
Exhibit L – Clinical Laboratory Report
Exhibit M – Medical Staff Report
Exhibit N – Health & Wellness Center Initiative Final Report

Executive Summary

The Annual Report is comprised of an evaluation and summary of the planning, clinical, financial, and operational practices of the Telluride Medical Center's (TMC) Emergency Services and Primary Care (PC) practice for the calendar year 2013. The evaluations and audits presented to the Telluride Hospital District Board of Directors represent the "State of the Telluride Medical Center."

2013 Program Highlights

- Implementation of the Patient Care Coordinator position in Primary Care
- Instillation of Care Coordination Medical Record (CCMR) software as part of PC's EMR
- Wellness Counseling initiated for PC patients
- Retention of Dr. Heather Linder as a three day per week PC provider
- Trial expansion of the PC Medical Assistants to a fourth MA
- Dr. Sharon Grundy's use of Adaptive Change principles to create efficient processes

2013 Continuation of Keystone Programs

- The Carol M. White Physical Education Program (PEP) that TMC administers on behalf of the Department of Education in San Miguel County's two school districts is in the third and final year of the grant
- Finished year one of the CMS' Comprehensive Primary Care Initiative (CPCi) Program to transform how Primary Care medicine is delivered
- Continued the HRSA, RHITND and CDPHE grant to maintain and execute Chronic Disease Patient Registries and the Community Health Worker program

The TMC Foundation under the direction of Kate Wadley continues to build a solid base to begin a capital campaign when the need becomes necessary to build a new facility.

After a 10% reduction in THD's 2012 mill levy, 2013 saw an additional 1.3% cut. Despite the further erosion in the mill levy support TMC had another solid financial year. In 2013, Primary Care (PC) and the Emergency Department (ED) visits were up by 5% and 9% respectfully over 2012.

Over the last year, the Telluride economic indicators have been mixed. Telluride's sales tax saw a 6.8% increase during 2013 over 2012. 2012-13 skier days were up by 2% over the previous season. The 2013 real estate sales were down by 6% and the real estate activity was down by 8% over 2012. Judi Keirnan of Telluride Consulting reports that the local real estate market is still on an overall upward trend. Based on TMC's 2013 performance and the local economic indicators led TMC management to project a flat budget forecast for the Emergency Services and a 3% increase in patient visits in 2014 for Primary Care.

Looking forward, there remain some significant statewide and federal issues to be resolved in 2014. Most notably is the impact of the statewide Health Insurance Exchange.

2013 Annual Report

I. **Executive Director's Report** (See Exhibit A)
- The Executive Director's Report is a brief outline of the last year's activities, developments, and strategic planning.

II. District Description – General Information

a. Board Members, Officers', Titles and Terms

Board Member	Officer	Title	Term Expiration Year
Bill Grun	Yes	Chair	Resigned Dec, 2013
Andrew Karow	Yes		Appointed Dec, 2013 – 5/6/2014
Dan Garner	Yes	Vice-President	2016
Carol Kammer	Yes	Secretary	2014
Albert Roer	Yes	Treasurer	2014
Larry Mallard	Yes	Chair as of Jan, 2014	2016

b. Changes in board membership in the past year
- Mr. Bill Grun resigned as Chair of the Telluride Hospital District Board at the conclusion of the December 13, 2013 THD board meeting. Mr. Larry Mallard was appointed Chair following Bill's resignation. Andrew Karow was appointed to the District's board to fill Bill's vacated seat.

c. Name and address for official contact for district:
Gordon Reichard, TMC Executive Director
PO Box 1229
Telluride, CO 81435

d. Elections held in the past year and their purpose
- No THD Board election was held in 2013. Three seats will be up for election in May, 2014.

III. Boundary changes for the report year and proposed changes for the coming year
- There were no THD boundary changes in 2013 and none anticipated in 2014.

IV. List of IGA's (existing or proposed) and brief description of each detailing financial and service arrangement
- The Telluride Medical Center holds a sublease from the Town of Telluride for the building it occupies. The lease is paid up through the term in 2032 and thus does not represent a liability.

V. **Service Plan Update** (if changed within the last year)
   a. List and describe services authorized in the service plan.
      - The original 1983 Service Plan and each subsequent amendment to the service plan has authorized a "Community Clinic and Emergency Center" at the Telluride Medical Center. It has not changed in the last year.
   b. List and describe any changes of services authorized in the service plan.
      - The TMC services remain the same as articulated in the original 1983 Service Plan
   c. List and describe any extraterritorial services, facilities and agreements.
      - No extraterritorial services, facilities and agreements listed

VI. **Development Progress** (Tracking progress)
   a. List and describe completed projects within reporting period, indicate dates of completion, dates of operation.
      - No "completed projects" within 2013. Our last project was the Emergency Department expansion and remodel which was completed in 2010.
   b. List projects under construction with anticipated dates of completion/operation.
      - No "projects were under construction" within 2013
   c. List completed commercial and industrial properties indicate dates of completion, dates of operation.
      - As a Hospital District, THD had no "completed commercial and industrial properties" within 2013
   d. List planned number of housing units by type, the number of commercial and industrial properties with respective square footage, if known and anticipated dates of completion/operation.
      - No "planned housing units or commercial/industrial properties" considered by the Telluride Hospital District (THD).
      - However, THD has plans to eventually build a replacement facility within the District. No anticipated dates of completion are known at this time.
   e. List any enterprises created by and/or operated by or on behalf of the District and summarize the purpose of each.
      - No new "enterprises" have been created within 2013.

VII. Financial Activities, Plan and Report
   a. TMC's 2013 Financial Annual Report – See Exhibit B
   b. Provide copy of audit or exemption from audit (reporting year).
      - Telluride Hospital District is required as a local government entity to provide for an independent audit of the Statements of Net Position and the related Statements of Revenue, Expenses and Changes in Net Position and Statements of Cash Flows for each calendar year. As of today, we have not prepared a 2013

Management Discussion and Analysis. The 2012 Audited Financial Statement, Letter and the Management Discussion and Analysis are provided.

- See Exhibit C – DWC Audit Recommendation Letter
- See Exhibit C – 2012 Audited Financial Statements

c. Provide copy of Annual Operating Budget (showing previous and budget year).
   - See Exhibit D

d. Show actual revenues and expenditures for the previous year
   - See Exhibit D

e. Specifically include developer advances, IGA revenues and property tax revenues. For the same period, show actual and projected mill levies by purpose (showing mill levies for each individual general obligation or contractual obligations).
   - THD paid no developer advances in 2013. Actual and projected mill levies are shown in Exhibit E.

f. Provide detailed information on each authorized by unissued debt obligation (include ballot issue letter designation and election date, amounts authorized and un-issued, purpose).
   - THD had no unissued debt obligation in 2013

g. Provide detailed information on all other financial contractual obligations
   i. Describe type of obligation, current year dollar amount and any changes in payment schedule, e.g., "balloon" payments.
      - TMC has a copier lease. Monthly payments are - $325
   ii. Report any inability of the District to pay current obligations (due within current budget year).
      - THD had the ability to pay all financial obligations in 2013
   iii. Describe any notice of default of any District financial obligations
      - THD received no notices of default on their financial obligations

h. Actual and Assessed Valuation History
   i. Report annual, actual and assessed valuation for current year and for each of the seven years prior to the current year.
      - See Exhibit F
   ii. For each year, compare the certified assessed value with the Service Plan estimate for that year (if provided in Plan). If Service Plan estimates are not available, indicate the same and report certified value.
      - THD's 1983 THD Service Plan has no estimated assessed values to compare. See Exhibit F for Certified Assessed Value.

i. Mill Levy History and Information
   i. Report annual mill levy for current year and for each of seven years prior to current year, broken out of purpose: general operations, debt by issue, contractual obligations, other (describe briefly).
      - See Exhibit F

ii. For each year, compare the actual mill levy with the Service Plan estimate for the year (If provided in plan). If Service Plan estimates are not available, indicate the same and report actual mill levies
- THD's 1983 THD Service Plan has no estimated mill levy revenue to compare. See Exhibit E for Actual Mill Levy values.

iii. Indicate any change in mill levies from limited to unlimited.
- None of THD mill levies changed from limited to unlimited during 2013.

j. Estimate amount of additional General Obligation debt to be issued by District between end of current year and 100% build-out. Do not include Refunding Bonds

i. Provide updated estimate based on current events.
- THD had no General Obligation debt in 2013 or plan to issue in the next year

ii. Compare debt issuance and currently outstanding debt to the maximum authorized debt level as stipulated in the service plan.
- THD has issued no debt in the past 12 months. There is no mention of an authorized debt level in the 1983 THD Service Plan

VIII. TMC Foundation Report (See Exhibit G)

The TMC Foundation continues to grow in their presence in the community and their financial support of the Telluride Medical Center. Please see the complete Foundation report in Exhibit G

IX. Annual Primary Care & Emergency Department Reports (See Attached Exhibit H & I)

The Primary Care and Emergency Department Annual Report is comprised of a summary report, quality assurance findings and recommendations derived from a medical record review. The reports represent a compilation of findings and recommendations from the clinical staff.

a. **Emergency Department (ED) Report:** The ED is under the medical direction of Dr. Diana Koelliker and Ms. Melissa Tuohy, Nurse Manager. They compiled the ED Report under Exhibit H.

b. **Primary Care/Community Clinic Report:** Under the direction of Dr. Sharon Grundy, Medical Director of the Primary Care and Mr. Eric Johnson, Nurse Practitioner and clinic manager; they compiled the report attached as Exhibit I.

X. Annual Ancillary Services Reports (See Attached Exhibits J, K & L)

Annual summary reports and recommendations for correction plans (if necessary) of the clinical and organizational activities associated with radiological, pharmacy, and laboratory services are included.

a. **Radiology:** Ms. Cheryl Fitzhugh, RT, the Radiology Services Manager prepared an annual report of the activities, successes and issues that faced the service in the past year. See Exhibit J.

b. **Pharmacy:** Ms. Betsy Muennich, RN, ED Nurse prepared an annual report of the activities, successes and issues that faced the service in the past year. See Exhibit K.
c. **Laboratory:** Mr. Eric Johnson, NP-C manages our laboratory services and he has prepared an annual report of the activities, successes and issues that faced the service in the past year. See Exhibit L.

XI. Medical Staff Report

- Dr. Dan Hehir, TMC's Chief of Staff compiled the Medical Staff Report. See Exhibit M

XII. Policy and Procedure Review

All policies and procedures are reviewed on an annual basis to ensure compliance with the latest standards of operation and management. The following departmental policies listed were reviewed and/or revised in 2013.

Primary Care

- Primary Care reviewed and updated their policy on reporting critical lab values

Trauma and Emergency Services

- The Emergency Department reviewed all their policies and procedures and made no significant edit

Clinical Laboratory

- Revised the Critical Lab Values P&P
- Revised the In House Lab P&P

Radiology

- Revised the Radiology Paperwork
- Revised the Call reports
- Revised the After Hours CT Call Reports
- Revised the ER Radiology Requests

Patient's Business Office

- Revised the Patient & Insurance Refunds
- Revised the Athena and Discount on Patient Balance

Human Resources

- Updated and revised the Employee Handbook in the following areas:
    - Paid Time Off (PTO) taken up to maximum available – i.e., cannot go negative on PTO
    - FMLA benefits extended to domestic partners and civil unions
    - Garnishment of wages expense born by employee

- Annual Flu Shot requirements outlined

Environment of Care

- Environment of Care reviewed all their policies and procedures and made no significant edits

XIII. 2013 Accomplishments

The following list of accomplishments was compiled from the TMC managers. Many of these accomplishments are explained in further detail elsewhere in the Annual Report.

Telluride Medical Center (TMC)

1. THD/TMC continued affiliation with St. Mary's Hospital in Grand Junction
2. The Carol M. White Physical Education Program was approved for its third year of a three year grant
3. Our Communication Consultant in tandem with the TMC providers began a successful weekly Medical Moments e-blast to our community regarding contemporary medical issues
4. The Communications Consultant began the "What couldn't you live without" campaign to draw attention to the critical value of the medical center in the community
5. Signed new leases with the orthopedic visiting specialists
6. Care Flight and St. Mary's Hospital flight program reviewed three potential building sites in March 2013 for helicopter access
7. An outside consultant completed an HR audit in April 2013
8. TMC staff participated in an airport tabletop emergency preparedness exercise in March 2013
9. Health Management Services distributed their first dividend check to TMC
10. Beginning in May, 2013, THD participated with the Health & Wellness Center Initiative which studied potential building sites for a new medical center, whether or not a medical campus could be developed by attracting medical practices/businesses to Telluride and whether a developer would be interested in backing a medical campus development
11. Executive Director attended a MSEC Benefits Conference in anticipation of the ACA roll-out
12. THD and TMC met with the Telluride Fire Protection District to better understand their development needs
13. Andrew Karow joined the THD board, replacing long time board chair Bill Grun
14. Medical Detox meeting held with the county, Sheriff and Marshall's Department to determine a long range plan
15. Proposition 2D passed on November 5, 2013 to allow the Town of Telluride to develop what is commonly known as the RV Parking Lot for Public Use
16. A digital sign was installed in the TMC waiting room

17. 2013 all TMC staff were immunized with the annual flu shot as required by TMC policy
18. Continued to collaborate with Public Health on pandemic and natural disaster preparedness

Primary Care (PC)

1. The Patient Care Coordinator developed Care Teams with the providers to review high risk empanelled patients
2. Maintained the Chronic Disease Registry for Diabetes and Cardiovascular Disease
3. "Reach Out and Read" program to improve childhood literacy was the largest in the state of Colorado
4. PC staffed with 3 providers Monday through Friday
5. Achieved all 2013 Comprehensive Primary Care Initiative (CPCi) Milestones;
   A. Started a Patient Advisory Council for PC
6. Paula Scheidegger hired as a Patient Care Coordinator in March 2013
7. Patient Centered Medical Home software installed in December, 2013
8. Wellness Counseling began June 6, 2013
9. Primary Care's Electronic Medical Record (EMR) achieved Phase I Meaningful Use status
10. Both the May Health Month and October Health Fair ran smoothly with many appreciative community comments on the benefit of the events
11. Continued HRSA grant for Diabetes and CVD
12. PC volume up by 5% over 2012
13. Lab inspection occurred with no deficiencies
14. TMC Pharmacy was inspected with zero deficiencies
15. Installed Care Coordination Medical Record (CCMR) software for Patient Care Coordinator to use to track patients care efficiency
16. Temporarily instituted the 4th MA in December, 2013 to improve patient flow and MA/provider satisfaction
17. A pre-test on job satisfaction surveys was given before the fourth MA was conducted for all PC staff and found an overall score of 3.3 out of 5.0 or 65.4% job satisfaction. The survey will be repeat in the spring of 2014
18. Developed an Asthma Chronic Disease Registry
19. Helped train and worked with Tri-County Health Network's local Community Health Worker
20. Achieved full implementation of the Quality Health Network (QHN) bidirectional interface
21. PC continued to be a Vaccine For Children (VFC) provider

Emergency Department

1. Implemented an acute stroke protocol utilizing tPA
2. Replaced pediatric laryngoscope
3. Met quality measures in Emergency Department (ED) and Primary Care

4. Met with Representative Scott Tipton regarding our ED Bill Type Issue. Rep Tipton offered to write a letter on TMC's behalf to waive the stand-alone ED classification for TMC.
5. St. Mary's Hospital provided Neonatal Resuscitation Provider (NRP) training for the ED staff in the spring of 2013
6. Starting July 1, 2013, hired Dr. Simon Kotlyar to replace Dr. Hackett

Radiology

1. The Telluride Medical Center Foundation procured a new digital processing system for Radiology

Patient's Billing Office

1. Implemented monthly review of the Days in Accounts Receivable (DAR) Report
2. Implemented monthly review of the various Business Office performance standards
3. Implemented an online bill paying service – Bill.com to pay TMC's accounts payable
4. Distinguished Budget Presentation Award received from GFOA
5. 2013 chart audit was successful with no management recommendations

Telluride Medical Center Foundation

1. Assisted in organizing and hosting the 2013 Play for Pink Golf Tournament
2. 2013 End of the Year Appeal was the largest in Foundation history at $125,000 and funded the new Radiology Digital Processor

XIV. 2014 Goals

Telluride Medical Center

1. Continue to search for an appropriate building site to secure the long term future of the medical center

Primary Care

1. Primary Care will certify for Phase II of Meaningful Use II by the end of 2014
2. Upgrade to version 10 of eClinicalWorks:
    a. By upgrading to version 10 it will allow TMC to improve the patient registration experience due by allowing them to enter their patient history information into an iPad
    b. The Patient Portal will be upgraded to improve communication between the provider and the patient
3. Participate in the Tri-County Health Network's (TCHN) Chronic Diseases Registry/HRSA grant and partake in Population Health Management
4. Become a Level III certified Patient-Centered Medical Home in 2014

5. Continue outreach programs into the community such as – Medical Moments, health fairs, group nutritional counseling for diabetics and diabetic telehealth classes with a Certified Diabetic Educator
6. Analyze data to see if PC needs a fourth MA during busy seasons
7. Employ Christine Tealdi to assist Paula Scheidegger with Patient Care Coordination as funded by CPCi
8. Establish a two way interface with CIIS (the states vaccination record keeping system)

Emergency Department

1. Host the regional Certified Emergency Nurse (CEN) course
2. Continue emphasizing quality of care by monitoring quality measures
3. Ensure staff continue their collaboration with EMS and Public Health Department for Disaster Preparedness Drills
4. Continue to watch the ED electronic medical record technology to determine the best fit for implementation

Business Office

1. Move all medical forms to online to patients can complete prior to visit; and
2. Provide an iPad in the waiting area to eliminate paper forms.

Note:
If requested pursuant to CRS 32-1-207(3)(c), the report must be filed with the Board of County Commissioners, any municipally in which the district is wholly or partially located, the division of local government and the state auditor. The report shall be deposited with the county clerk and recorder for public inspection and made available by the district to any interested party via their website.

Exhibit A

Executive Director's Report
For the period of January 1, 2013 to December 31, 2013

The Telluride Medical Center is licensed by the State of Colorado as a Community Clinic/Emergency Center (CC/EC). The medical center's license was current through 2013.

Telluride's economy has been mixed over the past twelve (12) months. Real Estate sales have lagged behind 2012 but accommodation occupancy and ADR were at record levels in 2013. Total paid skier days in 2012-'13 were up 2% over the previous season and the group visits were up by 8%.

Financially TMC exceeded its projected 2013 net revenue by $241,000. The 2013 budget was projected to have a breakeven net revenue before the year began but due largely to the increase in grant supported programs and a 5% increase in Primary Care visits, TMC finished in the black. Please see Exhibit B for further details.

2013 has seen the following program accomplishments:

- Over the summer and fall, THD/TMC participated with the Health & Wellness Center Initiative to: 1) Study the possibilities of expanding Telluride's medical services, 2) evaluate the properties best suited for a medical center, and 3) determine if there was a role for a developer to alleviate public bond financing of a new facility. Activities of the Initiative were sponsored by the Telluride Foundation with an eye toward settling the question of whether there could be a grander facility and medical campus that would be an economic engine to the area. The Executive Committee felt that there was a critical window of opportunity to complete such a comprehensive study because the disappearance of suitable building sites in the District and once built the window will effectively closes for 50 years. See Exhibit N for the Final Report.
- During the spring and summer of 2013 the Telluride Medical Center Foundation (TMCF) had a Single Audit of their 2012 finances due to the fact it had greater than $500,000 in federal grant monies during the year. Currently, the TMCF has a federal grant for the Carol M. White Physical Education Program (PEP) that the foundation is operating on behalf of the two school districts within San Miguel County. The Foundation also works with the Tri-County Health Network (TCHN) to host several of their federal grants that benefit TMC as well as many of the surrounding medical facilities in the transformation of Primary Care delivery and population health management. The Single Audit reported no material finding although there were two recommendations:
    1. All expense invoices and contractor time sheets must be signed, dated and approved by the independent contractor and the Program Director; and

2. The Telluride Medical Center Foundation board must have knowledge of the activities of the grants passing through their account.

- The Comprehensive Primary Care Initiative (CPCi) showed considerable growth in 2013. Beginning in November of 2012, CPCi identified nine Milestones that needed completion in 2013 as a condition of participant in the program. The Centers for Medicare and Medicaid Services (CMS) partnered with six major insurance carriers to offer a per member per month (PMPM) payment to the participating practices in Arkansas, Colorado, New Jersey, New York, Ohio, Kentucky, Oklahoma and Oregon. The goal of this project is to reduce the overall cost of healthcare, improve the quality of medicine, and engage patient's more actively in their own care. TMC was selected as a practice site through a competitive application process based on our use of health information technology, our demonstrated use of advanced patient care delivery methods, our service to patients covered by participating payors, our participation in practice transformation and improvement activities. The Initiative is a four year program with shared saving set to begin in 2014 and be paid out in 2015. As a CPCi practice, we are responsible for the global healthcare costs of our "attributed" patients and will share in the savings of those costs thereby reducing the overall cost of healthcare.

  To insure that quality is not compromised while costs are reduced the practice follows the below CPCi criteria:

  1. **Manage Care for at Risk Patients:** Patients with serious or multiple medical conditions need far greater support outside of the practice. Therefore our practice delivers comprehensive care management services for high risk patients. High risk empanelled patients are tracked by the Patient Care Coordinators (PCC) who create a care plan that uniquely fits each patient's individual circumstances and values. The practice's PCCs daily monitor the patients compliance with their care plan and intervene as necessary. The PCCs work with the patient's provider to insure medications are modulated appropriately between visits, referring specialist's reports are part of the patient record and the patient is carefully following their specific care plan.
  2. **Ensure Access to Care:** Because health care needs and emergencies are not restricted to office operating hours, our PC practice is accessible to patients 24/7 via TMC's Emergency Medicine physicians. Patients have real-time access to their health record via TMC's patient portal.
  3. **Deliver Preventive Care:** Primary Care is able to proactively assess their patients to determine their needs and provide appropriate and timely preventive care.
  4. **Engage Patients and Caregivers**: TMC's Primary Care actively engages patients and their families to participate in their own care.
  5. **Coordinate Care Across the Medical Neighborhood**: Patient Care Coordinators, Navigators and Medical Assistants take the lead in coordinating the patients' experience and medical care. Under this Initiative, our providers and staff work together with a patient's other health care providers and the patient to make

decisions as a team, coordinate referrals and insure the patient's medical record contains all referring physician notes, and hospitalizations.

New to CPCi for 2013 was the function of a *Patient Care Coordinator* (PCC). Paula Scheidegger, who had previously been Dr. Sharon Grundy's Medical Assistant, took over the care coordination role in May. As part of her PCC role, Paula manages the Chronic Disease Patient Registry, diabetic education, administers the empanelled high risk patient care plans and assists with patient navigation through the medical neighborhood. She meets monthly with each of the Primary Care providers and his or her Medical Assistants to review the progress of their highest risk patients towards reaching their therapeutic goals (manages and monitors quality patient outcomes). Dennis Magana, MA has taken on the role of Referral Coordinator. To begin with, Dennis has been tasked with getting a routine colonoscopy screening program in place for all patients attributed to the practice over the age of 50. He follows up with the GI specialist to insure that the appointment has been met, a colonoscopy report sent back to the attending physician and then the patient has a follow up appointment with their Primary Care provider to review the results of the colonoscopy.

- The current Primary Care Medical Assistant's (MA) have been overwhelmed with the increased volume over the last year and a half plus the increased patient care placed on them. So in December, 2013 the THD Board of Directors approved a pilot program of adding a fourth MA in Primary Care. This program was designed to run during the winter ski season after which its success will be evaluated and reported to the Board. The board will then determine if the program should be continued during the traditionally high seasons (e.g. May Health Month, and then Bluegrass through summer). The goal of this program is to improve provider efficiency, promote the quality of care and reduce the stress of the MA position.

  The fourth MA will be responsible for:
  - Managing the lab visits and the day to day lab duties.
  - Pre-visit planning duties which includes:
    - Making sure all referral report from specialists, op reports, test or imaging results are on the chart
    - Making sure all pre-visit forms are completed – history and physical form or screening surveys
    - Pre-populating the visit note with available demographic and clinical information
  - Tracking letters for annual exams, mammography and chronic disease patients are sent
  - Lab reconciliation – Making sure all critical lab results are followed up on
  - Workers comp tracking
  - Refill prescription call backs to patient for clarification – faxing refill authorization to pharmacy on behalf of the provider
  - Screening provider calls – Serve as an intermediary between patient and their provider

- Assisting with Meaningful Use measures such as Risk Stratification (Dr. Grundy reports that a new patient to the practice requires 125 extra 'clicks' because of Meaningful User requirements)

- On November 5, 2013 Proposition 2D passed in the Town of Telluride allowing the "RV Lot" on Mahoney Drive to be used for "Public Use." While this ballot issue was placed on the ballot by the Town of Telluride, the friends of TMC through a Local Organizing Committee mounted a fervent campaign to inform the public that if the proposition did not pass, the medical center would be forced to leave the town because this was the last suitable parcel in Telluride for the medical center. The proposition enjoyed strong support passing by a margin of 61% to 39%. The Telluride Town Council will entertain two votes in the first quarter of 2014 to rezone the RV Lot for public use and amend the Master Plan to afford the partitioning of the land to form two parcels – 1) the RV Lot and 2) the rest of the Pearl Property being designated for conservation. It is understood that shortly after the second vote the council will determine the appropriate public use of the RV Lot.
- Much of the last quarter of 2013 was spent preparing for a budget that would have a $282,000 reduction in the Mill Levy support from the District due to the fall in assessed value within the District. The 2014 budget is projected to be breakeven with no increase in staff wages for the sixth year running. The staff has participated in an annual incentive program that has paid them roughly five percent of their annual compensation in the form of a bonus.
- Gordon Reichard, TMC's Executive Director met with Darlene Marcus, representative of US Congressman Scott Tipton in October 2013 to discuss the ED Bill Type which limits TMC's Medicare and Medicaid reimbursement. Gordon subsequently wrote a letter outlining the issues and the remedies sought over the last two years of investigation. Ms. Marcus has forwarded all information to an aide of Rep. Tipton who felt it may be feasible to give TMC a Center for Medicare and Medicaid (CMS) waiver to allow them to operate their Emergency Department as a stand-alone ER. TMC was told that there will be an answer by late February, 2014.
- In January, 2013 Dr. Peter Hackett, long time ER physician and renowned high altitude specialist retired from full-time employment at the medical center. He will continue with his Institute for Altitude Medicine research and consultation but largely from his home in Ridgway, Colorado. Dr. Simon Kotlyar was hired to replace Dr. Hackett and began his duties in July, 2013. Dr. Kotlyar came to us highly recommended from the Yale Medical Center in New Haven, Connecticut where he was an ER physician and headed their World Medicine program. In this capacity he was well suited to replace Dr. Hackett's travel medicine capacity with the local community.
- Primary Care added the services of Dr. Heather Linder in May of 2013. Dr. Linder works three shifts per week as a family practice physician and sees pediatric patients in Dr. Gaylord's absence.

- Beth Kelly, the medical center's Communications Consultant working with the Board's Communication Committee began an ad campaign to reinforce the essential value of the medical center in the community. The campaign was called "What You Can't Live Without" and it featured Telluridians talking about what they couldn't live without including the medical center and why. TMC has received many favorable comments about these ads as well as the weekly e-blast – *Medical Moments* that medical staff write. Kate Wadley is leading an effort to get Medical Moments underwritten to offset the 2014 lose of Mill Levy revenue.

There are several initiatives that management has been working on over the past year and will continue to pursue into 2014. They are:

A. The Patient Care Coordinator in Primary Care is calling back all PC patients that come into the ED
B. Primary Care implemented Care Coordination Medical Record (CCMR) software from eClinicalWorks in June of 2013. As of the first of 2014, the program still is not functioning as advertised. CCMR is designed and sold to be the backbone of the work the Patient Care Coordinators. A functioning CCMR is critical to achieving the shared saving in year 2 of CPCi.
C. TMC realized a savings of 12% by ordering pharmaceutical and medical supplies through the Premier/Adventist GPO over the last 12 months
D. Primary Care held the first Patient Advisory Council in September, 2013 to seek advise about patient care improvements and how to engage patient's in their care
E. The Annual Gary Wright Skin Cancer Clinic will be on March 8, 2014
F. PC will meet Phase II Meaningful Use for the PC EMR

The Following are Ongoing Programs

The U.S. Department of Education's Carol M. White Physical Education Program (PEP) that TMC administers in San Miguel County's two school districts is in the third of a three year grant. PEP continues to have a very positive impact on school-aged students with the addition of a school garden and grow-dome, access to a variety of free extracurricular fitness and nutrition activities and increased nutrition education in the schools.

Dr. Sharon Grundy spearheaded the formation of a PC Efficiency Team in June. She has introduced the use of Herringbone Diagrams to the department to identify improvement opportunities. The exercises have been particularly beneficial because each member of the team can be comfortable with expressing their voice and therefore have ownership in the proposed changes to improve efficiency and the quality of care delivered.

The Telluride Hospital District board along with TMC's management worked together to update and further refine the Strategic Plan. The 2013 Strategic Plan can be found on the Medical Center's website – Tellmed.org.

THD continues to enjoy a very beneficial working relationship with St. Mary's Medical Center in Grand Junction. THD signed an affiliation agreement with St. Mary's in 2007 and has since met twice a year to exchange ideas and support each other. During the past Annual Report period, there have been two high level meeting with St. Mary's executive team to discuss the performance of our affiliation and the future desired outcomes for the relationship.

The Hospital District Board with assistance of outside consultants and administration continue to examine the possibilities of building a new facility. As of this writing five suitable sites have been identified within the District. The aforementioned passage of Proposition 2D has given impetus to this search. It is incumbent upon the Telluride Hospital District Board of Directors to find the most suitable parcel of land with the most favorable terms to house a medical center that will serve the health needs of this community over the next 50 years. Size of the facility and funding has not been determined. It is anticipated that THD will release an RFP during the first quarter of 2014 to determine the relative merits of the five properties. Possible locations under consideration are the Town of Telluride, Society Turn or Mountain Village.

EXHIBIT B

2013 Financial Annual Report
Julie Wesseling, Financial Director

Financially, 2013 was an extremely positive year with many unexpected events that improved the financial situation. First and foremost, in the fall of 2012, TMC received a notice of award from the Centers for Medicare and Medicaid Services that it was one of 74 primary care practices in Colorado to receive the Comprehensive Primary Care Initiative (CPCi). The financial impact of this grant was unknown when the budget was adopted. In addition, TMC was the recipient of a State initiative through membership in the Tri-County Healthcare Network. Looking back, these grants had a substantial impact on the 2013 revenue and costs and are the cause of several variances.

Also deemed noteworthy, the 2013 Emergency Department visits were projected to remain flat and in reality grew 9.6% and the Primary Care visits, projected to grow 7.5% due to the impact of Dr Homer's office closing in 2012, only grew 5.5%. Despite the strong influx of visits in both departments, patient revenues in both departments missed the mark by a couple of percentage points.

Below is a list of the other variances which were unexpected.

- Significant increases in clinical costs related to 1) increased demand during the evening shift of the Emergency Department, 2) additional staff deemed necessary to both properly triage patients into the Primary Care department and 3) provide the transformational services required by the CPCi.
- Supply purchases dropped an additional 5% over the previous year purchase prices due to 1) continued participation in the Group Purchasing Organization membership and 2) a reduction in the availability of generic but essential medications
- Meaningful Use Incentives were maximized adding $24,000 to the net profits.
- The retirement of an emergency department physician created a variance related to benefits paid to an employee versus locum tenens.
- Telephone and internet costs were subsidized by USAC Funding and a postponed telephone upgrade saved $13,188.
- HRSA-RHITND grant offset Quality Health Network fees saving $7,800 and funded major equipment capital purchases of $16,025.
- Telluride Medical Center Foundation funded $113,000 for capital equipment purchases.
- Contingency funds of $10,000 remained unspent and therefore available.

Multiple unforeseen events helped end the year with a $242,233 positive variance from budget. Nearly all of the variance relates to grant revenues which were used to offset existing staff expenses and purchase capital assets.

More patients have access to insurance that was not available before but patient deductibles have increased as patients try to maintain their premiums at a manageable level. The year-ended with the self-pay account receivable balances decreasing 8% from the previous year-end which represents 33% of the outstanding balance of receivables as compared to 37% of the outstanding balance in 2012.

The Net Days in Accounts Receivable (A/R) increased one day and two days respectively over last year as evidenced by the Emergency Departments (ED) Days in Accounts Receivable (DAR) going from 68 days to 69 days and the Primary Care (PC) Days in Accounts Receivable (DAR) going from 36 to 38 days, respectively. This is attributed to the increase in payer claims at year end.

Our cash position remains strong. The year-end total cash stands at $2,504,683; a $391,040 improvement over December 2012. Included in this total is Restricted Cash of $625,000 of which $500,000 is Board restricted.

At the time of this report TMC does not have any investments other than the savings account balance and those interest rates are nominal. The Days Cash On-hand at the end of December was 123 as compared to 125 in 2012 and is calculated excluding the restricted funds. The Medical Center's standard established by the Finance and Audit Committee is to maintain 60 Days Cash on Hand throughout the year. Management's goal of 60 days of Cash On-hand is approximately $919,680.

The overall traffic to the medical center campus increased 5% in 2013 and consisted of 16,826 patients as compared to 16,040 patients in 2012. The Primary Care providers saw 10,343 patients and staff administered 3,229 other patient related exams consisting of counseling, blood draws, immunizations, imaging, and ultrasounds. Based on an anticipated increase, the Primary Care Dept hired an additional midlevel provider for ski season. Once the demand continued, the primary care increased staff permanently with an additional physician.

The Emergency Department saw 3,222 patients in 2013 an increase of 6% over the last year.

Overall, the Medicare and Medicaid (M/M) percentage of our commercial business comprises 19% (vs. 18.4% in the previous year) in Primary Care (PC) and 15% (vs. 12.8% last year) in the Emergency Department (ED). It is expected that the annual M/M volume will continue to trend up due to the aging baby boomer which is concerning due to their poor reimbursement. Every 1% increase in the M/M payer mix reduces reimbursement by an average of 45%.

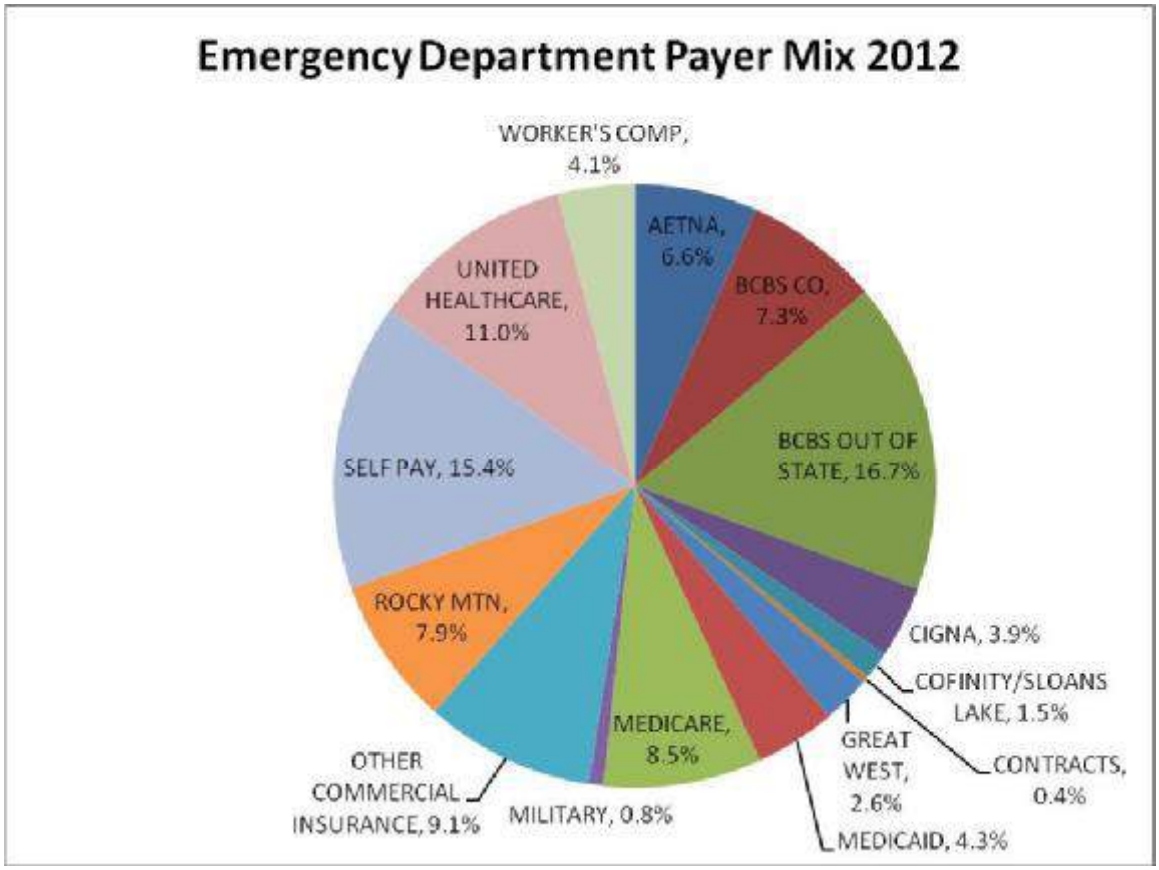
Another change in payer mix related to worker's compensation. The ED worker's compensation visits increased 5% while the primary care visits were down 15% indicating that the local construction economy is still depressed.

TMC's management goal is to constantly improve operations. In addition to providing electronic access to patients for both medical records and billing information, the Primary Care staff were able to maximize their work towards the federal government's requirements for Meaningful Use (MU). The staff must now focus on MU Stage 2 which has much higher standards. MU during 2013 resulted in incentive payments of $24,000 and not meeting would have resulted in a penalty. Participating in the Meaningful Use program promotes Quality Improvement within the practice; generating visit summary's for the patients, reconciling patient medications, notifying patients of needed office visits and more.

GRAPHICS

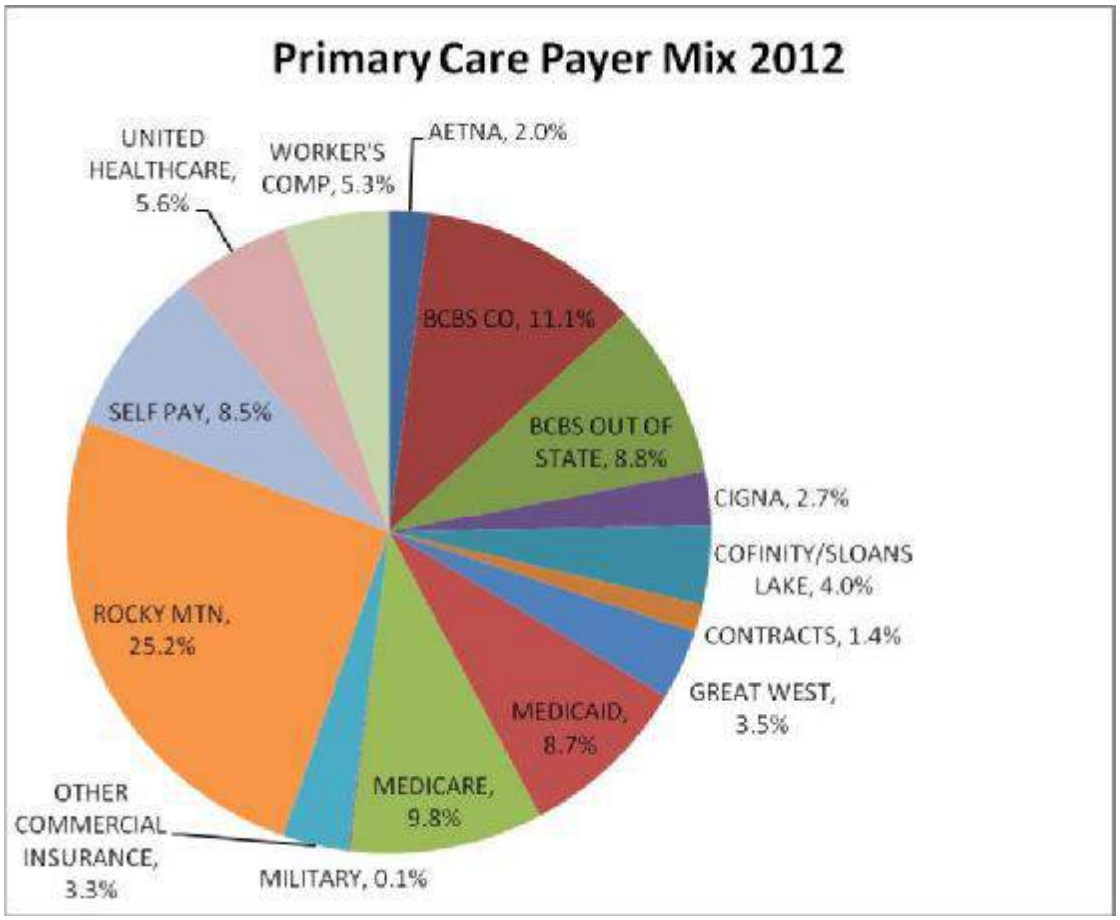
Emergency Department Payer Mix 2012 compared to 2011

ED Payer Categories	2012	2011	Difference between Yrs
BCBS OUT OF STATE	$ 500,813	$ 537,355	$ (36,542)
SELF PAY	$ 462,992	$ 471,353	$ (8,361)
OTHER COMMERCIAL INSURANCE	$ 352,569	$ 389,306	$ (36,737)
UNITED HEALTHCARE	$ 328,723	$ 274,649	$ 54,074
MEDICARE	$ 253,922	$ 198,429	$ 55,493
ROCKY MTN	$ 237,792	$ 256,885	$ (19,093)
BCBS CO	$ 218,065	$ 146,601	$ 71,464
AETNA	$ 197,615	$ 204,546	$ (6,931)
MEDICAID	$ 130,448	$ 96,364	$ 34,084
WORKER'S COMP	$ 123,201	$ 130,803	$ (7,602)
CIGNA	$ 116,156	$ 102,770	$ 13,386
GREAT WEST	$ 76,694	$ 54,194	$ 22,500



Primary Care Payer Mix 2012 compared to 2011

PC Payer Categories	2012	2011	Difference between Yrs
ROCKY MTN	$ 664,469	$ 573,932	$ 90,537
BCBS CO	$ 292,876	$ 239,360	$ 53,516
MEDICARE	$ 257,162	$ 225,267	$ 31,895
BCBS OUT OF STATE	$ 231,913	$ 216,328	$ 15,585
MEDICAID	$ 228,011	$ 210,627	$ 17,384
SELF PAY	$ 224,264	$ 275,097	$ (50,833)
UNITED HEALTHCARE	$ 148,391	$ 115,491	$ 32,900
WORKER'S COMP	$ 138,704	$ 122,134	$ 16,570
COFINITY/SLOANS LAKE	$ 104,224	$ 83,920	$ 20,304
GREAT WEST	$ 92,479	$ 58,493	$ 33,986
OTHER COMMERCIAL INSURANCE	$ 125,705	$ 129,745	$ (4,040)
CIGNA	$ 72,131	$ 60,263	$ 11,868
AETNA	$ 53,512	$ 65,600	$ (12,088)



TELLURIDE HOSPITAL DISTRICT

FINANCIAL STATEMENTS
AND
INDEPENDENT AUDITOR'S REPORT

December 31, 2012 and 2011

DALBY, WENDLAND & CO., P.C.
CPAs and Business Advisors

CPAs and Business Advisors

Grand Junction
464 Main Street • P.O. Box 430 • Grand Junction, CO 81502
Phone: (970) 243-1921 • Fax: (970) 243-9214

Board of Directors
Telluride Hospital District
Telluride, Colorado

INDEPENDENT AUDITOR'S REPORT

Report on the Financial Statements
We have audited the accompanying financial statements of the business-type activities and the blended component units of Telluride Hospital District (the District), as of and for the years ended December 31, 2012 and 2011, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. The financial statements of the Telluride Medical Center Foundation (Foundation) were audited in accordance with the *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinions
In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial positions of the business-type activities and the blended component units of the District as of December 31, 2012 and 2011, and the respective changes in financial position, and, where applicable, cash flows thereof for the years ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis and budgetary comparison information on pages 20 and 21 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Boards, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during out audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

DALBY, WENDLAND & CO., P.C.
Grand Junction, Colorado

June 19, 2013

REQUIRED SUPPLEMENTAL INFORMATION

TELLURIDE HOSPITAL DISTRICT

MANAGEMENT'S DISCUSSION AND ANALYSIS

For the year ended December 31, 2012

Telluride Hospital District (the District), dba Telluride Medical Center (TMC) operates two healthcare business units 1) a Trauma & Emergency Services Department offering a full service Level V Trauma Center providing emergency care twenty four hours a day seven days a week and 2) a Primary Care Department that is a multi-specialty medical practice with two doctors, two mid-level providers and visiting specialists.

TMC has two affiliated organizations: the Telluride Medical Center Foundation (TMCF), a charitable fundraising organization, and IFAM, the Institute for Altitude Medicine, an altitude medicine charitable research organization. These organizations operate separately and are included in the financial as component units of the District.

TMC is governed by a five member Board of Directors elected by the voters within a Special District established under Colorado law (the Telluride Hospital District).

Financial Overview

This discussion and analysis is intended to serve as an introduction to the District's basic financial statements, which are mainly comprised of four components:

- The Statements of Net Position provide information about the District's assets and liabilities and reflects the District's financial position as of December 31, 2012 and 2011.
- The Statements of Revenue, Expenses and Changes in Net Position report the cumulative activity of providing healthcare services and the expenses related to such activity for the years ended December 31, 2012 and 2011.
- The Statements of Cash Flows outline the cash inflows and outflows related to the activity of providing healthcare services for the years ended December 31, 2012 and 2011.
- The Notes to Financial Statements provide explanation and clarification on specific items within the previously mentioned financial statements and should be read in their entirety.

This report also contains other supplemental information in addition to the basic financial statements themselves.

1. Statements of Net Position

Financial Analysis

The District's total assets at the end of the 2012 calendar year were $7,537,249 as compared to $6,996,094 at the end of the 2011 calendar year. The $541,155 increase reflects an increase in cash of $477,845, an increase in due from affiliates of $67,694, accounts receivable $32,565, other assets of $33,595 plus an increase in other current assets of $24,094 offset by a decrease in ad valorem taxes of $38,445, and a decrease in capital assets of $86,774 related to depreciation. The increase in cash relates to approximately a 9% increase in net patient service revenue, and several unplanned events during the year including meaningful use proceeds of $32,151, Class action lawsuit proceeds of $22,238, and savings related to a group purchasing organization. In addition, staff made deliberate reductions where possible anticipating the reduction in ad valorem tax revenue as well as successful grant funding and fundraising efforts by the TMCF.

At December 31, 2012, assets consisted primarily of total cash of $2,563,063, net capital assets of $2,291,071, current year ad valorem taxes receivable of $1,821,878, and net patient accounts receivable of $502,503.

Comparable asset balances at December 31, 2011 were as follows: total cash of $2,085,218, net capital assets of $2,377,845, prior year ad valorem taxes receivable of $1,860,323, and net patient accounts receivable of $469,938.

The District's total liabilities at December 31, 2012 were $921,922 consisting of accrued liabilities of $669,039, and accounts payable and due to affiliates of $252,883. The increase in accrued liabilities of $178,943 reflects an increase in accrued compensation relating to the current year's incentive as well as an increase due to the timing of the pay period end. The increase in accounts payable and due to affiliates relates directly to the increased program support from the TMCF to the District.

Comparable liability balances at December 31, 2011 were as follows: Total liabilities of $686,926, consisting of accrued liabilities of $490,096, and accounts payable and Due to affiliates of $196,830.

The District's deferred inflows of resources at December 31, 2012 were $1,825,470 and the comparable balance in 2011 was $1,856,634. The decrease of $31,164 is a direct result of reduced ad valorem taxes relating to a drop in the District's assessed values. The District does not have any debt nor any estimated liability for potential losses.

2. Statements of Revenue, Expenses, and Changes in Net Position

Net Patient Service Revenue

The District's net patient service revenue is divided between revenues from its 24-hour emergency service (57%) and revenues from its primary care clinic (43%). However, the emergency service accounts for only 19% of the patient encounters while the primary care accounts for 81%. Eighty-eight percent (88%) of the District's patient charges are billable to insurance companies and 12% of charges are considered self pay or without insurance. Because payments for services rendered to patients under insurance programs are less than billed charges, the District estimates a provision for contractual adjustments to reduce the total charges to these patients to estimated receipts, based upon either the program's principles or the contractual arrangements. Due to the complicated nature of claim adjudication, the payments received could differ from the provision.

The District's revenues are classified as operating and non-operating revenues. Operating revenues consist of net patient service revenues and increased between the calendar years 2012 and 2011 by approximately 9%. Net patient service revenue for the 2012 calendar year was reported as $3,777,314 compared to the 2011 calendar year net patient revenue of $3,476,112. Patient visits increased 8% during 2012 due to a local primary care office closure.

The TMCF conducted fewer formal fundraisers in 2012 but had a very successful year raising $302,050 as compared to $311,143 in 2011. TMCF received grants in 2012 totaling $1,077,647 of which all funds were dispersed per the program. Comparable grants in 2011 totaled $308,077. The IFAM contributions and grants were minimal in 2012 due to both the economy and a planned reduction in fundraising.

Total non-operating revenues for the 2012 calendar year ended at $3,434,161, compared to the non-operating revenues in 2011 of $2,591,533. Non-operating revenue is comprised of ad valorem taxes, contributions and grants, interest income and other non-operating revenues. Ad valorem taxes are the biggest contributor to non-operating revenue and had a $198,715 decrease from 2011. Contributions and grants increased in 2012 related to the award of three separate federal grants. The District received $1,448,340 in contributions and grants in 2012 as compared to $461,558 in 2011.

The major expenses incurred by the District during the 2012 calendar year were compensation and employee benefits of $3,382,651 and $642,121, respectively; professional and consulting fees of $343,444; IT, equipment, and service contracts of $247,788; depreciation and amortization of $242,814 and materials and supplies of $242,006. Physician expenses were included in both compensation and contract services in 2012 and 2011 but reflect a change in employment status for the ER physicians beginning in February 2012.

TMCF had program expenses of $133,590 in 2012, which was an increase of $70,453 over 2011. Program expenses relate to activities that fulfill the TMCF mission which is to secure the financial resources required to ensure clinical excellence and the continued quality of care at the Telluride Medical Center. Other operating expenses such as a portion of compensation and benefits also qualify as program expenses but are classified using the same methodology as the District expenses. The program expense increase in 2012 includes an additional gift to the medical center of $64,926.

The District's net position at the end of the 2012 calendar year was $4,789,857 as compared to $4,452,534 at the end of the 2011 calendar year. The year progressed with better than anticipated revenues and expenses. The success of the TMCF also attributed to the increase in net assets.

Provision for Doubtful Accounts
The collection of receivables from patients and third party payers is the District's primary source of cash and is therefore, critical to the District's operating performance.

During the 2012 calendar year, the primary collection risks relate to the uninsured patient and to aged insurance claims. The District estimated the provisions for doubtful accounts based upon previous experience.

Significant changes in payer mix, economic conditions and trends in federal and state governmental healthcare coverage affect the District's collection of accounts receivable, cash flows, and results of operation. The provision for doubtful accounts for the 2012 calendar year was $118,044 and fully reserves all self-pay balances over 120 days old. The calendar year 2011 provision was $127,823.

3. Statements of Cash Flows

Liquidity and Capital Resources
The District's cash flows from operations and Ad valorem taxes provide the primary sources of funding for the District's ongoing cash needs.

The following is a summary of cash flows for the calendar years ended on December 31:

Cash Flows	2012	2011
Operating Activities	$ (1,340,278)	$ (1,487,716)
Non-Capital Financing Activity	1,996,204	2,124,377
Capital & Related Financing Activity	(156,040)	(46,177)
Investing Activities	(22,041)	11,979
Net Increase/(Decrease) in Cash	$ 477,845	$ 602,463

The net cash used by the District's cash flows from operating activities decreased in 2012 primarily due to the increased revenues in the Primary care.

The decrease in non-capital financing relates directly to the reduced ad valorem tax revenue offset by increased support from the TMCF.

The capital and related financing increase is due to the many purchases of medical and administrative equipment in 2012.

The $477,845 increase of cash is the result of favorable operating results.

Budgetary Highlights

The District is responsible for funding expenses from cash generated through its operations and from the ad valorem taxes received during the calendar year. The District prepares a budget to reflect the expected revenues and expenses generated through its operations. The District's Board of Directors approved an amended 2012 budget during the last quarter of the 2012 calendar year.

Economic and Other Factors

The days in accounts receivable ratio (DAR) at year end yielded 33 and 63 days in the Primary Care and Emergency Department business units, respectively. The healthy accounts receivable ratio is largely due to staff dedicated to working the self-pay accounts receivable. The Primary Care and Emergency Department DAR at year ended 2011 was 34 and 64, respectively. A distinctive issue for the District is the number of patient visitors from out of state presenting a non-participating insurance. Each insurance company has unique requirements for claim submission which most times require individual handling. During 2012, the District filed insurance claims with 1479 different insurance companies of which 42% were non-participating and represented 19% of the total patient revenue.

The day's cash on hand ratio at December 31, 2012 was 124 days versus day's cash on hand in December 2011 of 106 days. The increase is linked to increased revenue in the primary care due to a local office closure. Management will continue to monitor this ratio to ensure that adequate cash reserves are available.

A number of major factors affect the ongoing financial situation of the District. They are a combination of healthcare legislation, significant revenue cycle adjustments, and the cost of living in a resort community impacting the District's ability to retain qualified staff and remain the premier provider of healthcare in the region.

The table below reflects the reductions in revenue related to the Care Support program over the last three years.

Charity Care	2012	2011	2010
Emergency Department	$ 75,343	$ 105,111	$ 84,057
Primary Care Department	57,111	77,736	60,077
Total Charity Care	$ 132,454	$ 182,847	$ 144,134

Contacting the District's Financial Management

This management discussion and analysis report is designed to provide interested parties with a general overview of the District financial activity for the 2012 calendar year and to demonstrate the District's accountability for the money it received for providing healthcare services to members of this community and others. If you have questions about this report or need additional information, please contact Telluride Hospital District's Financial Director, 500 West Pacific Avenue, Telluride, CO 81435.

TELLURIDE HOSPITAL DISTRICT

STATEMENTS OF NET POSITION

December 31, 2012 and 2011

	2012				2011
	THD *	IFAM **	TMCF ***	**Total**	Total
ASSETS					
Current Assets					
Cash and cash equivalents	$ 2,113,643	$ 22,796	$ 426,624	**$ 2,563,063**	$ 2,085,218
Accounts receivable from patient services & pledges, net of estimated uncollectibles of $282,662 (2012) and $285,873 (2011)	456,191	935	45,377	**502,503**	469,938
Other receivables	32,153	-	-	**32,153**	10,350
Ad valorem taxes receivable	1,821,878	-	-	**1,821,878**	1,860,323
Due from affiliates	132,227	-	-	**132,227**	64,533
Inventory	95,154	-	-	**95,154**	86,376
Other current assets	65,605	-	-	**65,605**	41,511
Total Current Assets	4,716,851	23,731	472,001	**5,212,583**	4,618,249
Capital Assets, net	2,266,751	24,320	-	**2,291,071**	2,377,845
Other Assets	33,595	-	-	**33,595**	-
Total Assets	7,017,197	48,051	472,001	**7,537,249**	6,996,094
LIABILITIES					
Current Liabilities					
Accounts payable	104,201	-	16,455	**120,656**	132,670
Due to affiliates	679	-	131,548	**132,227**	64,160
Accrued compensation and employee benefits	566,550	-	-	**566,550**	398,160
Other accrued liabilities	102,489	-	-	**102,489**	91,936
Total Current Liabilities	773,919	-	148,003	**921,922**	686,926
Total Liabilities	773,919	-	148,003	**921,922**	686,926
DEFERRED INFLOWS OF RESOURCES					
Imposed nonexchange revenue - ad valorem taxes	1,825,470	-	-	**1,825,470**	1,856,634
Total Deferred Inflows of Resources	1,825,470	-	-	**1,825,470**	1,856,634
NET POSITION					
Invested in capital assets, net of related debt	2,266,751	24,320	-	**2,291,071**	2,377,845
Unrestricted components of net position					
Unrestricted	1,776,057	22,400	315,948	**2,114,405**	1,945,769
Board designated	250,000	-	-	**250,000**	-
Temporarily restricted components of net position	125,000	1,331	8,050	**134,381**	128,920
Total Net Position	$ 4,417,808	$ 48,051	$ 323,998	**$ 4,789,857**	$ 4,452,534

* Telluride Hospital District - See Note 1

** Institute for Altitude Medicine - See Note 1 and Note 13

*** Telluride Medical Center Foundation - See Note 1 and Note 14

See accompanying notes.

TELLURIDE HOSPITAL DISTRICT

STATEMENTS OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION

For the years ended December 31, 2012 and 2011

	2012				2011
	THD	IFAM	TMCF	**Total**	Total
Operating Revenues					
Net patient service revenue	$ 3,746,390	$ 30,924	$ -	**$ 3,777,314**	$ 3,476,112
Contribution and donation income	-	-	302,050	**302,050**	311,143
Other revenue	59,299	618	-	**59,917**	26,474
Total Operating Revenues	3,805,689	31,542	302,050	**4,139,281**	3,813,729
Operating Expenses					
Compensation	3,282,949	7,767	91,935	**3,382,651**	2,360,615
Contract services	73,206	3,735	-	**76,941**	1,052,722
Employee benefits	611,997	6,329	23,795	**642,121**	549,177
Program expenses	-	-	110,176	**110,176**	63,137
Professional and consulting fees	337,783	1,411	4,250	**343,444**	361,199
Other operating expenses	199,335	964	40,876	**241,175**	217,739
Materials and supplies	241,272	542	192	**242,006**	273,761
Depreciation and amortization	238,021	4,793	-	**242,814**	240,751
IT, equipment, and service contracts	237,980	9,808	-	**247,788**	213,524
Building and facilities	120,609	4,800	-	**125,409**	117,395
Utilities and support services	64,732	-	1,644	**66,376**	71,718
Insurance	75,290	586	1,067	**76,943**	52,962
Travel and entertainment	-	-	3,791	**3,791**	12,416
Research and development	-	405	-	**405**	25,254
Interest and loan fees	22	-	-	**22**	11
Total Operating Expenses	5,483,196	41,140	277,726	**5,802,062**	5,612,381
Income (Loss) From Operations	(1,677,507)	(9,598)	24,324	**(1,662,781)**	(1,798,652)
Non-operating Revenues					
Ad valorem taxes	1,906,168	-	-	**1,906,168**	2,104,883
Contributions and grants	348,504	22,189	1,077,647	**1,448,340**	461,558
Interest income	11,018	-	536	**11,554**	11,979
Other non-operating revenues	68,099	-	-	**68,099**	13,113
Total Non-operating Revenues	2,333,789	22,189	1,078,183	**3,434,161**	2,591,533
Non-operating Expenses					
Contributions and grants	155,896	-	1,077,647	**1,233,543**	334,901
Distribution to TMCF	195,035	-	-	**195,035**	102,345
Distribution to IFAM	5,479	-	-	**5,479**	4,800
Loss on disposal of plant	-	-	-	**-**	12,061
Total Non-operating Expenses	356,410	-	1,077,647	**1,434,057**	454,107
Total Non-operating Revenues, net	1,977,379	22,189	536	**2,000,104**	2,137,426
Increase in Net Position	299,872	12,591	24,860	**337,323**	338,774
Net Position - beginning of the year	4,117,936	35,460	299,138	**4,452,534**	4,113,760
Net Position - end of the year	$ 4,417,808	$ 48,051	$ 323,998	**$ 4,789,857**	$ 4,452,534

See accompanying notes.

TELLURIDE HOSPITAL DISTRICT

STATEMENTS OF CASH FLOWS

For the years ended December 31, 2012 and 2011

	2012				2011
	THD	IFAM	TMCF	**Total**	Total
Cash Flows From Operating Activities					
Cash received from patients and third-party payors	$ 3,714,591	$ 31,552	$ -	**$ 3,746,143**	$ 3,516,738
Cash received from other operating activities	37,496	618	186,639	**224,753**	252,611
Cash paid to suppliers and others	(1,314,856)	(19,950)	(158,371)	**(1,493,177)**	(1,449,196)
Cash paid to employees for services	(3,799,762)	(18,235)	-	**(3,817,997)**	(3,807,869)
Net Cash Provided (Used) by Operating Activities	(1,362,531)	(6,015)	28,268	**(1,340,278)**	(1,487,716)
Cash Flows From Non-capital Financing Activities					
Ad valorem taxes - Telluride Hospital District	1,913,449	-	-	**1,913,449**	2,105,302
Change in due to/from affiliate, net	(67,015)	-	67,388	**373**	(1,489)
Non-operating revenues	416,603	22,189	944,850	**1,383,642**	166,594
Non-operating expenses	(356,410)	-	(944,850)	**(1,301,260)**	(146,030)
Net Cash Provided by Non-capital Financing Activities	1,906,627	22,189	67,388	**1,996,204**	2,124,377
Cash Flows From Capital and Related Financing Activities					
Acquisition of property and equipment	(156,040)	-	-	**(156,040)**	(46,177)
Net Cash Used for Capital and Related Financing Activities	(156,040)	-	-	**(156,040)**	(46,177)
Cash Flows From Investing Activities					
Interest income received	11,018	-	536	**11,554**	11,979
Investment in HealthCare Management, Inc.	(33,595)	-	-	**(33,595)**	-
Net Cash Provided (Used) by Investing Activities	(22,577)	-	536	**(22,041)**	11,979
Increase in Cash and Cash Equivalents	365,479	16,174	96,192	**477,845**	602,463
Cash and Cash Equivalents - beginning of the year	1,748,164	6,622	330,432	**2,085,218**	1,482,755
Cash and Cash Equivalents - end of the year	$ 2,113,643	$ 22,796	$ 426,624	**$ 2,563,063**	$ 2,085,218

See accompanying notes.

TELLURIDE HOSPITAL DISTRICT

STATEMENTS OF CASH FLOWS

For the years ended December 31, 2012 and 2011

	2012				2011
	THD	IFAM	TMCF	**Total**	Total
Reconciliation of Operating Income (Loss) to Net Cash Used by Operating Activities:					
Income (loss) from operations	$ (1,677,507)	$ (9,598)	$ 24,324	**$ (1,662,781)**	$ (1,798,652)
Adjustments to reconcile operating loss to net cash used for operating activities:					
Bad debts	206,726	243	-	**206,969**	231,327
Provision for contractual adjustments	1,530,855	12,774	-	**1,543,629**	1,386,010
Depreciation and amortization	238,021	4,793	-	**242,814**	240,751
Loss on disposal of plant	-	-	-	**-**	12,061
Changes in:					
Patient accounts receivable	(1,769,380)	(12,389)	(1,394)	**(1,783,163)**	(1,603,097)
Other receivables	(21,803)	-	-	**(21,803)**	(6,541)
Inventory	(8,778)	-	-	**(8,778)**	7,165
Other current assets	(24,536)	442	-	**(24,094)**	24,112
Accounts payable and accrued liabilities	163,871	(2,280)	5,338	**166,929**	19,148
Net Cash Provided (Used) by Operating Activities	$ (1,362,531)	$ (6,015)	$ 28,268	**$ (1,340,278)**	$ (1,487,716)

See accompanying notes.

NOTE 1 - DESCRIPTION OF REPORTING ENTITY AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The accounting policies of Telluride Hospital District (the District) conform to accounting principles generally accepted in the United States of America (GAAP) as applicable to governments. The Governmental Accounting Standards Board (GASB) is the accepted standards setting body for establishing governmental financial reporting principles. The following is a summary of the District's significant accounting policies:

Financial Reporting Entity - The District was established in 1983 to operate and maintain a community health clinic and emergency center for the diagnosis and treatment of individuals requiring outpatient services and emergency care in the community and surrounding area of Telluride, Colorado.

The primary purpose of the District is to enhance and promote local health care by providing primary and emergency medical services, which includes establishing and operating a primary care medical center, TMC – Primary Care Enterprise and a 24-hour emergency medical care center, the Telluride Medical Center (TMC). In addition to its primary purpose, the District supports community health care through ongoing review and assessment of regional health care needs and cooperation with local, regional, state, and federal health care initiatives.

The financial statements of the District include all of the integral parts of the District's operations. To conform to GAAP as applicable to governments, criteria was considered to determine whether any organization should be included in the District's reporting entity. Based on these considerations, it was determined that the Institute For Altitude Medicine (IFAM), a separate legal entity, and the Telluride Medical Center Foundation (TMCF) meet the criteria to be included in the District's financial statements as blended component units. Additional financial information pertaining to the IFAM may be obtained from Institute For Altitude Medicine, P.O. Box 1229, Telluride, CO, 81435 (see Note 13). Additional financial information pertaining to the TMCF may be obtained from Telluride Medical Center Foundation, P.O. Box 1229, Telluride, CO, 81435 (see Note 14).

Accounting Standards - The District implemented GASB No. 62 Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements during the year ended December 31, 2012.

The District implemented GASB No. 63, *Financial Reporting of Deferred Outflows of Resources, Deferred Inflows of Resources, and Net Position* for the year ended December 31, 2012. GASB No. 63 implements a new presentation of certain assets as deferred outflows, certain liabilities as deferred inflows, and also replaces the term net assets with net position. The effect of implementation of GASB No. 63 for the District was a reclassification of deferred revenues to deferred inflows of resources.

Risk Management - The District is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruptions; errors and omissions; employee injuries and illnesses; natural disasters; and employee health and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the five preceding years (see Note 12 for discussion of coverage related to medical malpractice claims).

Use of Estimates - The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents - Cash and cash equivalents may include investments in highly liquid debt instruments with an original maturity of three months or less. The Board of Directors has designated assets required to meet capital expenditures. These designated assets are included in cash and cash equivalents. During 2012 the Board designated $250,000 to be used in the future purchase of land and a new facility.

Patient Receivables - Patient receivables are uncollateralized patient and third-party payor obligations. Payments of patient receivables are allocated to the specific claims identified on the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

The carrying amount of patient receivables is reduced by a valuation allowance that reflects management's estimate of amounts that will not be collected from patients and third-party payors. Management reviews patient receivables by payor class and applies percentages to determine estimated amounts that will not be collected from third parties under contractual agreements and amounts that will not be collected from patients due to bad debts. Management considers historical write off and recovery information in determining the estimated bad debt provision.

Ad Valorem Taxes - As of December 31, 2012 and 2011, the District's mill levy consisted of general operating expenses and a special levy for emergency medical care. Property taxes for the current year are levied in December of the previous year and attach as a lien on property the following January 1. They are payable in full by April 30 or in two equal installments due February 28 and June 15. Property taxes for 2012 are reportable as a receivable and deferred inflows of resources at December 31. The deferred taxes are reported as revenue in the year in which the lien attaches and they are available and collected.

Inventory - Supply inventories are stated at the lower of cost or market, determined using the first-in, first-out method.

Capital Assets - Property and equipment are recorded at cost, or if donated, at fair market value at the date of receipt. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method.

Net Position - Net position is presented in the following components:

***Net investment in capital assets* -** Invested in capital assets, net of related debt consists of capital assets, net of accumulated depreciation and reduced by the current balances of any outstanding debt used to finance the purchase or construction of those assets.

***Unrestricted component of net position* -** Unrestricted component of net position is the net amount of the assets, deferred outflows of resources, liabilities, and deferred inflows of resources that are not included in the determination of net investment in capital assets or the restricted component of net position.

***Temporarily restricted component of net position* -** Temporarily restricted component of net position is used to differentiate resources, the uses of which are specified by donors or grantors, from resources of the unrestricted component of net position on which donors or grantors place no restrictions or that arise as a result of the District operating for its stated purposes. Donor restrictions for specific purposes are reported in other operating revenue to the extent used within the period. Temporarily restricted components of net position for plant replacement and expansion are added to the unrestricted component of net position balance when expended.

Accrued Compensated Absences - The District accrues paid time-off in the period the related liability vests with the respective employee. Paid time-off is granted to all full-time employees and is vested based on years of service.

Net Patient Service Revenue - The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

Financial Hardship - The District provides care to patients who meet certain criteria under its financial hardship policy without charge or at amounts less than its established rates. Because the District does not pursue collection of amounts determined to qualify as financial hardship, they are not reported as revenue.

In-Kind Contributions - The District, specifically TMCF and IFAM, receives in-kind contributions to be used towards salaries and rent expense, respectively. Donated rent is recorded at its estimated value at the date of receipt. In 2012, TMCF recorded $132,797 as in-kind revenues and expenses.

Income Taxes - As an essential government function of San Miguel County, the District is generally exempt from income taxes under Section 115 of the Internal Revenue Code and a similar provision of state law. The District is no longer subject to U.S. Federal or state income tax examinations by tax authorities for years before 2008.

Reclassifications - Certain reclassifications have been made to the 2011 financial statements to conform to the 2012 presentation. The reclassifications had no effect on the results of operations.

NOTE 2 - BUDGETS

The District adheres to the following procedures in establishing the budgetary data reflected in the financial statements:

A. Budgets are required by state law.

B. Public hearings are conducted by the District to obtain taxpayer comments.

C. Prior to December 31, the budget is adopted and appropriations are made by formal resolution.

D. Expenditures may not legally exceed appropriations. Board of Directors approval is required for changes in the budget. Budget amounts included in the financial statements are based on the final, legally amended budget. The District's original budgeted expenditures were $5,790,650 and the final budgeted expenditures were $6,002,833 for the year ended December 31, 2012.

E. Budget appropriations lapse at the end of each year.

F. The District adopts budgets that include all financing sources and uses. The following is a budgetary comparison and a summary of the adjustments necessary to convert to the budgetary basis from GAAP used in presentation of the statements of revenue and expenses - unrestricted funds for the year ended December 31, 2012:

	Actual	Budget	Variance - Favorable (Unfavorable)
Revenue:			
GAAP-based revenue	$ 3,805,689	$ 3,872,583	$ (66,894)
GAAP-based non-operating revenue	2,333,789	2,151,926	181,863
Total Budgetary Revenue	$ 6,139,478	$ 6,024,509	$ 114,969
Expenses:			
GAAP-based expenses	$ 5,483,196	$ 5,589,720	$ 106,524
GAAP-based non-operating expenses	356,410	283,113	(73,297)
Adjustments:			
Capital outlay	156,040	130,000	(26,040)
Total Budgetary Expenses	$ 5,995,646	$ 6,002,833	$ 7,187

NOTE 3 - TAX, SPENDING, AND DEBT LIMITATIONS

Effective January 1, 2003, the District adopted a resolution that formalized the establishment of the TMC – Primary Care Enterprise as an enterprise under Article X, Section 20 of the Colorado Constitution, as amended (the TABOR amendment), which has several limitations including revenue raising, spending abilities, and other specific requirements of state and local governments. The TABOR amendment is complex and subject to judicial interpretation. The District believes it is in compliance with the requirements of the Amendment. However, the District has made certain interpretations of the TABOR amendment's language in order to determine its compliance. As stipulated in a resolution adopted by the District dated December 11, 2002, pursuant to and in accordance with the TABOR amendment, the TMC – Primary Care Enterprise shall be excluded from the provisions of the TABOR amendment.

NOTE 4 - CASH AND CASH EQUIVALENTS

The Colorado Public Deposit Protection Act (PDPA) governs the District's cash deposits. The statutes specify eligible depositories for public cash deposits, which must be Colorado institutions and must maintain federal insurance on deposits held. Each eligible depository with deposits in excess of the insured levels must pledge a collateral pool of defined eligible assets, to be maintained by another institution or held in trust for all of its local government depositors as a group, with a market value equal to at least 102% of the uninsured deposits. The State Regulatory Commissions for banks and savings and loan associations are required by statute to monitor the naming of eligible depositories and the reporting of uninsured deposits and assets maintained in the collateral pools.

The District had bank balances at December 31 as follows:

	2012	2011
Insured (FDIC) or collateralized with securities held by the District	$ 599,456	$ 528,093
Collateralized by securities held by the pledging financial institution in accordance with PDPA	2,025,036	1,503,713
Total	$ 2,624,492	$ 2,031,806
Carrying Value	$ 2,563,063	$ 2,085,218

Custodial Credit Risk - Deposits

Custodial credit risk for deposits is the risk that in the event of bank failure the District would not be able to recover the value of its deposits. The District's deposits are not deemed to be exposed to custodial credit risk as they are held by the District, or the District's custody agent in the District's name.

Concentrations of Credit Risk – Deposits

Concentrations of credit risk is the risk of loss attributed to the magnitude of a government's investment in a single issuer or institution. The District holds 96 % of its cash deposits in one financial institution and 4% in a second institution.

NOTE 5 - CAPITAL ASSETS

Property and equipment activities for the years ended December 31 were as follows:

2012	Beginning Balance	Additions	Deletions	Transfers	Ending Balance
Building improvements	$ 2,457,165	$ 18,137	$ -	$ -	$ 2,475,302
Medical equipment	1,115,877	94,096	15,625	-	1,194,348
Furniture and fixtures	65,614	-	-	-	65,614
Administrative equipment	212,572	43,807	7,485	-	248,893
Total Cost	3,851,228	156,040	23,110	-	3,984,157
Less accumulated depreciation and amortization:					
Building improvements	553,400	88,685	-	-	642,439
Medical equipment	703,153	124,596	15,625	-	811,769
Furniture and fixtures	58,501	2,394	-	-	60,895
Administrative equipment	158,329	27,139	7,485	-	177,983
Total Accumulated Depreciation and Amortization	1,473,383	242,814	23,110	-	1,693,086
Capital assets, net	$ 2,377,845	$ (86,774)	$ -	$ -	$ 2,291,071

2011	Beginning Balance	Additions	Deletions	Transfers	Ending Balance
Building improvements	$ 2,470,698	$ -	$ 13,533	$ -	$ 2,457,165
Medical equipment	1,105,179	27,632	16,934	-	1,115,877
Furniture and fixtures	65,614	-	-	-	65,614
Administrative equipment	220,751	18,546	26,725	-	212,572
Software	8,996	-	8,996	-	-
Total Cost	3,871,238	46,178	66,188	-	3,851,228
Less accumulated depreciation and amortization:					
Building improvements	466,945	88,083	1,628	-	553,400
Medical equipment	596,555	123,376	16,778	-	703,153
Furniture and fixtures	56,107	2,394	-	-	58,501
Administrative equipment	158,155	26,899	26,725	-	158,329
Software	8,996	-	8,996	-	-
Total Accumulated Depreciation and Amortization	1,286,758	240,752	54,127	-	1,473,383
Capital assets, net	$ 2,584,480	$ (194,574)	$ 12,061	$ -	$ 2,377,845

NOTE 6 - INVESTMENT IN HEALTHCARE MANAGEMENT, INC.

The District invested in Healthcare Management, Inc. (HCM) during 2012. The District has a 0.5% ownership interest in HCM. HCM is a for-profit limited liability corporation that owns and operates two companies that provide self-pay recovery services for hospitals and medical billing offices. Management of the District identified the investment in HCM as a potential source of income as mill levy proceeds continue to decrease.

NOTE 7 - EMPLOYEE BENEFITS

Retirement Plan - The District has a deferred compensation plan (the Plan) through annuity contracts with Colorado County Officials and Employees Retirement Association (CCOERA) in accordance with Section 457(b) of the Internal Revenue Code (IRC). The Plan allows participating employees to defer a portion of their compensation for retirement purposes. The deferred compensation is invested for the participants by the District under the agreements in the Plan. Under provisions of the IRC, all Plan assets are considered to be the property of the eligible participants and are, therefore, not considered to be assets of the District.

The District has offered a 401(a) Plan (the Plan) through CCOERA. Under terms of the Plan, all employees who have completed one year of service are eligible to participate. Participants may defer a portion of their compensation up to specified limits according to the IRC. The District will match 3% of the participants' contributions for a Plan month. For the years ended December 31, the District contributed $85,802 (2012) and $58,566 (2011) to the Plan.

Accrued Compensated Absences - The District's program pays for paid time-off (PTO) earned by regular, full-time employees. An employee may maintain a maximum of 300 PTO hours. Upon reaching 300 PTO hours, no additional time will accrue in an employee's PTO bank. At December 31, accrued PTO was $169,951 (2012) and $165,183 (2011).

NOTE 8 - LINE OF CREDIT

On December 10, 2012, the District renewed its line of credit ($400,000) with an interest rate of 0.025 percentage points over prime rate, with a 5% floor (5.0% at December 31, 2012 and 2011). This agreement has a maturity date of January 1, 2014. The line is collateralized by accounts receivable, inventory and equipment. As of December 31, 2012 and 2011, there were no draws on the line of credit.

NOTE 9 - NET POSITION

The District is required to report information regarding its financial position and activities according to three components of net position. The table below represents the District's financial position and activities at December 31, 2012:

THD	Invested in Capital Assets	Unrestricted	Unrestricted – Board Designated	Temporarily Restricted	Permanently Restricted	Total
Beginning net position	$ 2,348,732	$ 1,644,204	$ -	$ 125,000	$ -	$ 4,117,936
Fixed asset additions	156,040	(156,040)	-	-	-	-
Transfers to board designated	-	(250,000)	250,000	-	-	-
Increases in net position	(238,021)	537,893	-	-	-	299,872
Ending net position	$ 2,266,751	$ 1,776,057	$ 250,000	$ 125,000	$ -	$ 4,417,808

IFAM	Invested in Capital Assets	Unrestricted	Unrestricted – Board Designated	Temporarily Restricted	Permanently Restricted	Total
Beginning net position	$ 29,113	$ 2,427	$ -	$ 3,920	$ -	$ 35,460
Components of net position released from restriction	-	2,589	-	(2,589)	-	-
Increases in net position	(4,793)	17,384	-	-	-	12,591
Ending net position	$ 24,320	$ 22,400	$ -	$ 1,331	$ -	$ 48,051

TMCF	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Beginning net position	$ 299,138	$ -	$ -	$ 299,138
Components of net position released from restriction	4,800	(4,800)	-	-
Increases in net position	12,010	12,850	-	24,860
Ending net position	$ 315,948	$ 8,050	$ -	$ 323,998

NOTE 10 - OPERATING LEASES

The District has a non-cancellable operating lease for rental of office equipment. This is set to expire in 2017. Lease expense for the years ended December 31 was $2,925 (2012) and $0 (2011). Future minimum lease payments for the years ending December 31 are as follows:

2013	$ 3,900
2014	3,900
2015	3,900
2016	3,900
2017	975
	$ 16,575

NOTE 11 - CONCENTRATIONS OF CREDIT RISK

The District is located in Telluride, Colorado and grants credit without collateral to its patients, who are local residents of, and visitors to, the San Miguel County, Colorado area. Most patients are insured under third-party payor agreements.

Receivables from patients and third-party payors were as follows at December 31:

	2012	2011
Other third-party payors	53.6%	57.7%
Patient self-pay	37.3%	34.2%
Medicare	5.2%	4.5%
Medicaid	3.9%	3.6%

A summary of net patient service revenue for the years ended December 31 was as follows:

	2012	2011
Patient service revenue		
Emergency care	$ 2,981,827	$ 2,869,380
Community clinic	2,634,598	2,380,263
IFAM	43,941	40,801
Gross Patient Service Revenue	5,660,366	5,290,444
Financial hardship	(132,454)	(182,847)
Gross Patient Service Revenue, Net of Financial Hardship	5,527,912	5,107,597
Contractual adjustments	(1,543,629)	(1,400,158)
Provision for bad debts	(206,969)	(231,327)
Net Patient Service Revenue	$ 3,777,314	$ 3,476,112

NOTE 12 - CONTINGENCIES

Malpractice Insurance - The District purchases professional and general liability insurance coverage to cover medical malpractice claims. These are known claims and incidents that may result in the assertion of additional claims, as well as claims from unknown incidents that may be asserted arising from services provided to patients. This insurance coverage is on a "claims-made" basis.

The District's management, using information provided by its insurance carrier, has determined that the estimated liability for potential losses incurred, but not reported at December 31, 2012 and 2011, is not material to the accompanying financial statements. Accordingly, no provision for such losses has been accrued.

Litigation - The District is, at times, involved in litigation arising in the normal course of business. Management has consulted with legal counsel and estimates that these matters will be resolved without a material impact on the operations or financial position of the District.

Grant Repayment - The District received a special initiatives grant in 2010 from the Telluride Foundation in support of the Telluride Medical Center Remodeling Project in the amount of $125,000. The grant set forth a condition that requires the District to remain in the facility located at 500 West Pacific Avenue for five years. If the District does not remain in the facility through 2015, they would be required to repay the grant in full. The District's management has determined there is a remote possibility that the grant would need to be repaid based on the amount of time required to build a new facility and the substantial amount of money required to fund the project. This grant is classified a temporarily restricted component of net position in the statements of net position at December 31, 2012 and 2011.

NOTE 13 - INSTITUTE FOR ALTITUDE MEDICINE

The Institute for Altitude Medicine (IFAM) was founded during 2007 to provide clinical care and consultation, conduct research and develop educational programs to optimize health as well as treat medical issues affecting people who either live at, or travel to, high altitude. IFAM is a not-for-profit, organized under section 501(c)(3) of the Internal Revenue Code.

IFAM received a gift in-kind from the District for the years ended December 31, 2012 and 2011 in the form of rent. The cost of office facilities, which are used by IFAM in connection with operations, is not reflected in IFAM in the statement of position because asset title remains with the District. IFAM has reported contribution revenue and program expense amounting to $4,800 in the accompanying statement of revenue, expenses and changes in net position for the free use of the facilities during the years ended December 31, 2012 and 2011.

NOTE 14 - TELLURIDE MEDICAL CENTER FOUNDATION

During 2009, the Telluride Medical Center Foundation (TMCF) was formed exclusively for charitable purposes for the benefit of the District. TMCF is a not-for-profit, organized under section 501(c)(3) of the Internal Revenue Code.

As of December 31, TMCF had a payable to the District of $131,548 (2012) and $64,160 (2011).

As of December 31, TMCF had $302,050 (2012) and $311,143 (2011) of contribution and donation income, of which $104,389 (2012) and $102,345 (2011) was an in-kind donation from the District.

During 2012, TMCF was awarded four grants. The first, the Carol M. White Physical Education Program (PEP) provides grants to community-based organizations to initiate, expand, or enhance physical education programs, including after-school programs, for students in kindergarten through 12th grade. Revenue for 2012 and 2011 related to the PEP grant was $488,307 and $152,519, respectively. For 2012, TMCF also received $132,797 in in-kind donations related to the PEP grant. Of that in-kind, $90,646 was support from the District. For the years ended December 31, 2012 and 2011, all monies were spent in the year received.

TMCF was awarded three grants under CFDA#93.912, The Rural Health Network Development Planning Grant Program (RHNDP) is to expand access to, coordinate and improve the quality of essential health care services and enhance the delivery of health care, in rural areas. And, the Small Health Care Provider Quality Improvement Program to support rural public, rural non-profit, or other providers of healthcare services, such as a critical access hospital or rural health clinic. Revenue for 2012 and 2011 related to the three RHNDP grants was $456,543 and $155,558, respectively. For the years ended December 31, 2012 and 2011, all monies were spent in the year received.

NOTE 15 - FINANCIAL HARDSHIP

The District provides care to patients who meet certain criteria under its financial hardship policy without charge or at amounts less than its established rates. Because the District does not pursue collection of amounts determined to qualify as financial hardship, they are not reported as revenue.

The District determines the costs associated with financial hardships by aggregating the applicable direct and indirect costs, including salaries, wages and benefits, medical equipment and supplies, pharmacy, and other operating expenses, based on data from its costing system. Financial hardship costs for the years ended December 31, 2012 and 2011 were $207,045 and $182,847, respectively.

NOTE 16 - SUBSEQUENT EVENTS

The District has evaluated subsequent events through June 19, 2013, the date at which the financial statements were available to be issued, and determined that no events have occurred that required disclosure.

OTHER SUPPLEMENTAL INFORMATION

TELLURIDE HOSPITAL DISTRICT

SCHEDULE OF REVENUE, NON-OPERATING REVENUES, EXPENSES
AND NON-OPERATING EXPENSES - BUDGET AND ACTUAL

For the year ended December 31, 2012

	Budgeted Amounts			Favorable (Unfavorable)
	Original	Final	THD Actual	Variance
Operating Revenues				
Net patient service revenue	$ 3,607,174	$ 3,814,211	$ 3,746,390	$ (67,821)
Other revenue	45,321	58,372	59,299	927
Total Operating Revenues	3,652,495	3,872,583	3,805,689	(66,894)
Non-operating Revenues				
Ad valorem taxes	1,879,857	1,886,435	1,906,168	19,733
Contributions and grants	14,700	212,252	348,504	136,252
Interest income	10,300	10,500	11,018	518
Other non-operating revenues	18,500	42,739	68,099	25,360
Total Non-operating Revenues	1,923,357	2,151,926	2,333,789	181,863
Total Budgetary Revenues, net	$ 5,575,852	$ 6,024,509	$ 6,139,478	$ 114,969
Operating Expenses				
Compensation	$ 3,345,352	$ 3,351,777	$ 3,282,949	$ 68,828
Contract services	18,350	68,816	73,206	(4,390)
Employee benefits	677,555	629,855	611,997	17,858
Materials and supplies	296,765	258,515	241,272	17,243
Depreciation and amortization	244,080	237,417	238,021	(604)
IT, equipment, and service contracts	233,849	230,444	237,980	(7,536)
Building and facilities	115,390	113,339	120,609	(7,270)
Insurance	91,919	72,767	75,290	(2,523)
Other operating expenses	660,890	626,790	601,872	24,918
Total Operating Expenses	5,684,150	5,589,720	5,483,196	106,524
Non-operating Expenses				
Contributions and grants	6,500	178,368	155,896	22,472
Distribution to TMCF	-	102,345	195,035	(92,690)
Distribution to IFAM	-	2,400	5,479	(3,079)
Total Non-operating Expenses	6,500	283,113	356,410	(73,297)
Capital Outlay	100,000	130,000	156,040	(26,040)
Total Budgetary Expenses	$ 5,790,650	$ 6,002,833	$ 5,995,646	$ 7,187

See independent auditor's report.

TELLURIDE HOSPITAL DISTRICT

SCHEDULE OF REVENUE, NON-OPERATING REVENUES, EXPENSES,
AND NON-OPERATING EXPENSES - DEPARTMENTS

For the year ended December 31, 2012

	Emergency Care	Primary Care	THD Total
Operating Revenues			
Net patient service revenue	$ 2,142,520	$ 1,603,870	$ 3,746,390
Other revenue	1,354	57,945	59,299
Total Operating Revenues	2,143,874	1,661,815	3,805,689
Operating Expenses			
Compensation	2,390,370	892,579	3,282,949
Contract services	60,000	13,206	73,206
Employee benefits	435,503	176,494	611,997
Professional and consulting fees	202,176	135,607	337,783
Other operating expenses	153,715	45,620	199,335
Materials and supplies	115,748	125,524	241,272
Depreciation and amortization	238,021	-	238,021
IT, equipment, and service contracts	224,027	13,953	237,980
Building and facilities	119,212	1,397	120,609
Utilities and support services	59,847	4,885	64,732
Insurance	62,035	13,255	75,290
Interest	-	22	22
Total Operating Expenses	4,060,654	1,422,542	5,483,196
Income (Loss) from Operations	(1,916,780)	239,273	(1,677,507)
Non-operating Revenues			
Ad valorem taxes	1,846,441	59,727	1,906,168
Contributions and grants	151,159	197,345	348,504
Interest income	10,721	297	11,018
Other non-operating revenues	45,566	22,533	68,099
Total Non-operating Revenues	2,053,887	279,902	2,333,789
Non-operating Expenses			
Contributions and grants	14,607	141,289	155,896
Distribution to TMCF	104,389	90,646	195,035
Distribution to IFAM	4,800	679	5,479
Total Non-operating Expenses	123,796	232,614	356,410
Total Non-operating Revenues, net	1,930,091	47,288	1,977,379
Increase in Net Position	$ 13,311	$ 286,561	$ 299,872

See independent auditor's report.

EXHIBIT C

TELLURIDE HOSPITAL DISTRICT

MANAGEMENT'S DISCUSSION AND ANALYSIS

For the year ended December 31, 2012

Telluride Hospital District (the District), dba Telluride Medical Center (TMC) operates two healthcare business units 1) a Trauma & Emergency Services Department offering a full service Level V Trauma Center providing emergency care twenty four hours a day seven days a week and 2) a Primary Care Department that is a multi-specialty medical practice with two doctors, two mid-level providers and visiting specialists.

TMC has two affiliated organizations: the Telluride Medical Center Foundation (TMCF), a charitable fundraising organization, and IFAM, the Institute for Altitude Medicine, an altitude medicine charitable research organization. These organizations operate separately and are included in the financial as component units of the District.

TMC is governed by a five member Board of Directors elected by the voters within a Special District established under Colorado law (the Telluride Hospital District).

Financial Overview

This discussion and analysis is intended to serve as an introduction to the District's basic financial statements, which are mainly comprised of four components:

- The Statements of Net Position provide information about the District's assets and liabilities and reflects the District's financial position as of December 31, 2012 and 2011.
- The Statements of Revenue, Expenses and Changes in Net Position report the cumulative activity of providing healthcare services and the expenses related to such activity for the years ended December 31, 2012 and 2011.
- The Statements of Cash Flows outline the cash inflows and outflows related to the activity of providing healthcare services for the years ended December 31, 2012 and 2011.
- The Notes to Financial Statements provide explanation and clarification on specific items within the previously mentioned financial statements and should be read in their entirety.

This report also contains other supplemental information in addition to the basic financial statements themselves.

1. Statements of Net Position

Financial Analysis

The District's total assets at the end of the 2012 calendar year were $7,537,249 as compared to $6,996,094 at the end of the 2011 calendar year. The $541,155 increase reflects an increase in cash of $477,845, an increase in due from affiliates of $67,694, accounts receivable $32,565, other assets of $33,595 plus an increase in other current assets of $24,094 offset by a decrease in ad valorem taxes of $38,445, and a decrease in capital assets of $86,774 related to depreciation. The increase in cash relates to approximately a 9% increase in net patient service revenue, and several unplanned events during the year including meaningful use proceeds of $32,151, Class action lawsuit proceeds of $22,238, and savings related to a group purchasing organization. In addition, staff made deliberate reductions where possible anticipating the reduction in ad valorem tax revenue as well as successful grant funding and fundraising efforts by the TMCF.

At December 31, 2012, assets consisted primarily of total cash of $2,563,063, net capital assets of $2,291,071, current year ad valorem taxes receivable of $1,821,878, and net patient accounts receivable of $502,503.

Comparable asset balances at December 31, 2011 were as follows: total cash of $2,085,218, net capital assets of $2,377,845, prior year ad valorem taxes receivable of $1,860,323, and net patient accounts receivable of $469,938.

The District's total liabilities at December 31, 2012 were $921,922 consisting of accrued liabilities of $669,039, and accounts payable and due to affiliates of $252,883. The increase in accrued liabilities of $178,943 reflects an increase in accrued compensation relating to the current year's incentive as well as an increase due to the timing of the pay period end. The increase in accounts payable and due to affiliates relates directly to the increased program support from the TMCF to the District.

Comparable liability balances at December 31, 2011 were as follows: Total liabilities of $686,926, consisting of accrued liabilities of $490,096, and accounts payable and Due to affiliates of $196,830.

The District's deferred inflows of resources at December 31, 2012 were $1,825,470 and the comparable balance in 2011 was $1,856,634. The decrease of $31,164 is a direct result of reduced ad valorem taxes relating to a drop in the District's assessed values. The District does not have any debt nor any estimated liability for potential losses.

2. Statements of Revenue, Expenses, and Changes in Net Position

Net Patient Service Revenue

The District's net patient service revenue is divided between revenues from its 24-hour emergency service (57%) and revenues from its primary care clinic (43%). However, the emergency service accounts for only 19% of the patient encounters while the primary care accounts for 81%. Eighty-eight percent (88%) of the District's patient charges are billable to insurance companies and 12% of charges are considered self pay or without insurance. Because payments for services rendered to patients under insurance programs are less than billed charges, the District estimates a provision for contractual adjustments to reduce the total charges to these patients to estimated receipts, based upon either the program's principles or the contractual arrangements. Due to the complicated nature of claim adjudication, the payments received could differ from the provision.

The District's revenues are classified as operating and non-operating revenues. Operating revenues consist of net patient service revenues and increased between the calendar years 2012 and 2011 by approximately 9%. Net patient service revenue for the 2012 calendar year was reported as $3,777,314 compared to the 2011 calendar year net patient revenue of $3,476,112. Patient visits increased 8% during 2012 due to a local primary care office closure.

The TMCF conducted fewer formal fundraisers in 2012 but had a very successful year raising $302,050 as compared to $311,143 in 2011. TMCF received grants in 2012 totaling $1,077,647 of which all funds were dispersed per the program. Comparable grants in 2011 totaled $308,077. The IFAM contributions and grants were minimal in 2012 due to both the economy and a planned reduction in fundraising.

Total non-operating revenues for the 2012 calendar year ended at $3,434,161, compared to the non-operating revenues in 2011 of $2,591,533. Non-operating revenue is comprised of ad valorem taxes, contributions and grants, interest income and other non-operating revenues. Ad valorem taxes are the biggest contributor to non-operating revenue and had a $198,715 decrease from 2011. Contributions and grants increased in 2012 related to the award of three separate federal grants. The District received $1,448,340 in contributions and grants in 2012 as compared to $461,558 in 2011.

The major expenses incurred by the District during the 2012 calendar year were compensation and employee benefits of $3,382,651 and $642,121, respectively; professional and consulting fees of $343,444; IT, equipment, and service contracts of $247,788; depreciation and amortization of $242,814 and materials and supplies of $242,006. Physician expenses were included in both compensation and contract services in 2012 and 2011 but reflect a change in employment status for the ER physicians beginning in February 2012.

TMCF had program expenses of $133,590 in 2012, which was an increase of $70,453 over 2011. Program expenses relate to activities that fulfill the TMCF mission which is to secure the financial resources required to ensure clinical excellence and the continued quality of care at the Telluride Medical Center. Other operating expenses such as a portion of compensation and benefits also qualify as program expenses but are classified using the same methodology as the District expenses. The program expense increase in 2012 includes an additional gift to the medical center of $64,926.

The District's net position at the end of the 2012 calendar year was $4,789,857 as compared to $4,452,534 at the end of the 2011 calendar year. The year progressed with better than anticipated revenues and expenses. The success of the TMCF also attributed to the increase in net assets.

Provision for Doubtful Accounts
The collection of receivables from patients and third party payers is the District's primary source of cash and is therefore, critical to the District's operating performance.

During the 2012 calendar year, the primary collection risks relate to the uninsured patient and to aged insurance claims. The District estimated the provisions for doubtful accounts based upon previous experience.

Significant changes in payer mix, economic conditions and trends in federal and state governmental healthcare coverage affect the District's collection of accounts receivable, cash flows, and results of operation. The provision for doubtful accounts for the 2012 calendar year was $118,044 and fully reserves all self-pay balances over 120 days old. The calendar year 2011 provision was $127,823.

3. Statements of Cash Flows

Liquidity and Capital Resources
The District's cash flows from operations and Ad valorem taxes provide the primary sources of funding for the District's ongoing cash needs.

The following is a summary of cash flows for the calendar years ended on December 31:

Cash Flows	2012	2011
Operating Activities	$ (1,340,278)	$ (1,487,716)
Non-Capital Financing Activity	1,996,204	2,124,377
Capital & Related Financing Activity	(156,040)	(46,177)
Investing Activities	(22,041)	11,979
Net Increase/(Decrease) in Cash	$ 477,845	$ 602,463

The net cash used by the District's cash flows from operating activities decreased in 2012 primarily due to the increased revenues in the Primary care.

The decrease in non-capital financing relates directly to the reduced ad valorem tax revenue offset by increased support from the TMCF.

The capital and related financing increase is due to the many purchases of medical and administrative equipment in 2012.

The $477,845 increase of cash is the result of favorable operating results.

Budgetary Highlights

The District is responsible for funding expenses from cash generated through its operations and from the ad valorem taxes received during the calendar year. The District prepares a budget to reflect the expected revenues and expenses generated through its operations. The District's Board of Directors approved an amended 2012 budget during the last quarter of the 2012 calendar year.

Economic and Other Factors

The days in accounts receivable ratio (DAR) at year end yielded 33 and 63 days in the Primary Care and Emergency Department business units, respectively. The healthy accounts receivable ratio is largely due to staff dedicated to working the self-pay accounts receivable. The Primary Care and Emergency Department DAR at year ended 2011 was 34 and 64, respectively. A distinctive issue for the District is the number of patient visitors from out of state presenting a non-participating insurance. Each insurance company has unique requirements for claim submission which most times require individual handling. During 2012, the District filed insurance claims with 1479 different insurance companies of which 42% were non-participating and represented 19% of the total patient revenue.

The day's cash on hand ratio at December 31, 2012 was 124 days versus day's cash on hand in December 2011 of 106 days. The increase is linked to increased revenue in the primary care due to a local office closure. Management will continue to monitor this ratio to ensure that adequate cash reserves are available.

A number of major factors affect the ongoing financial situation of the District. They are a combination of healthcare legislation, significant revenue cycle adjustments, and the cost of living in a resort community impacting the District's ability to retain qualified staff and remain the premier provider of healthcare in the region.

The table below reflects the reductions in revenue related to the Care Support program over the last three years.

Charity Care	2012	2011	2010
Emergency Department	$ 75,343	$ 105,111	$ 84,057
Primary Care Department	57,111	77,736	60,077
Total Charity Care	$ 132,454	$ 182,847	$ 144,134

Contacting the District's Financial Management

This management discussion and analysis report is designed to provide interested parties with a general overview of the District financial activity for the 2012 calendar year and to demonstrate the District's accountability for the money it received for providing healthcare services to members of this community and others. If you have questions about this report or need additional information, please contact Telluride Hospital District's Financial Director, 500 West Pacific Avenue, Telluride, CO 81435.

EXHIBIT C

DALBY, WENDLAND & CO., P.C.

CPAs and Business Advisors

Grand Junction

464 Main Street • P.O. Box 430 • Grand Junction, CO 81502
Phone: (970) 243-1921 • Fax: (970) 243-9214

To the Board of Directors
Telluride Hospital District
Telluride, Colorado

In planning and performing our audit of the financial statements of Telluride Hospital District (the District) as of and for the year ended December 31, 2012, in accordance with auditing standards generally accepted in the United States of America, we considered the District's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

This communication is intended solely for the information and use of the Board of Directors, management, others within the District, and is not intended to be and should not be used by anyone other than these specified parties.

Dalby, Wendland & Co, P.C.

DALBY, WENDLAND & CO., P.C.
Grand Junction, Colorado

June 19, 2013

EXHIBIT E

Telluride Hospital District
Mill Levy broken out by purpose

	2014	2013	2012	2011
Mill Levy - General Operations	$671,180	$ 794,449	$ 827,182	$ 917,729
Mill Levy - 24HR Emergency Services	$859,111	$ 1,018,895	$ 1,058,793	$ 1,174,525
Mill Levy - Abatements	$5,158	$ 8,105	$ 20,199	$ 12,629
	$ 1,535,449	$ 1,817,449	$ 1,906,174	$ 2,104,884

EXHIBIT E

Telluride Hospital District
Mill Levy broken out by purpose

	2013	2012	2011
Mill Levy - General Operations	$ 794,449	$ 827,182	$ 917,729
Mill Levy - 24HR Emergency Services	$ 1,016,895	$ 1,058,793	$ 1,174,525
Mill Levy - Abatements	$ 8,105	$ 20,199	$ 12,629
	$ 1,817,449	$1,906,174	$ 2,104,884

EXHIBIT F

Telluride Hospital District
Assessed Value Mill Levy History

			Actual Mills & Purpose			
	Actual and Assessed Valuation History	Certified Value	General Operating	Special 24 Hr Emergency Operations	Abatements	GO Bond
2014	870,366,350	670,366,350	1.0	1.280	0.008	0
2013	794,449,500	794,449,500	1.0	1.280	0.007	0
2012	805,684,320	805,684,320	1.0	1.280	0.007	0
2011	899,025,280	899,025,280	1.0	1.280	0.024	0
2010	893,454,757	893,454,757	1.0	1.280	0.014	0
2009	779,024,260	779,024,260	1.0	1.280	0.004	0
2008	784,580,460	764,580,460	1.0	1.280	0.008	0
2007	641,150,870	641,150,870	1.0	1.281	0.033	0.289
2008	644,653,770	644,653,770	1.0	1.281	0.009	0.287
2005	491,384,840	491,384,840	1.0	1.281	-	0.372

Service plan estimates ere not aveilable.

EXHIBIT G

2013 Annual Report
Telluride Medical Center Foundation
Kate Wadley, Executive Director

- **Telluride Medical Center Foundation:**
  1. 2013 was Major Gift annual campaign focused
  2. 2013 End of year total $211,000 – Largest End-of-the-Year-Appeal yet
  3. Ongoing updating the Wall of Appreciation on the exterior entrance of the Emergency Department
  4. Sold out Play for Pink Golf Tournament. TMCF was the major benefactor.
  5. Band-Aids & BBQ was July 3 and was deemed a major success.
  6. Executive Director achieved Incentive Objectives for 2013
  7. The 2013 Year End Appeal funded the Radiology Digital Processor

- **Foundation Database:**
  1. Grew the Foundation mailing list in e-Tapestry database – An additional 255 contacts were added.

- **2014 Goals:**
  1. Identify and cultivate major donors to contribute to the new Medical Center
  2. The major giving opportunity for 2014 will be a new ultrasound machine and a digital PACS system for Radiology (~$100,000)
     (TMCF has purchased for TMC over the past 5 years: OB- GYN Stretcher, Analyzer, Orthoscan 1000 , New Infant Care Station, Chemical Analyzer, and the Radiology Digital Processor
  3. The Executive Director will solicit underwriters for TMC's weekly e-blast "Medical Moments"
  4. In 2014 the TMCF will recruit new board member and develop a Fundraising Committee to assist with a Capital Campaign for a new facility
  5. The Foundation will detail a road map for Major Gifts in 2014. They will develop a top 100 prospects and top 100 pipeline list
  6. Achieve Incentive Objectives for 2014
  7. Develop a Capital Campaign Strategy in advance of property becoming available
  8. Secured Play for Pink for June 30, 2014 and will again be the major benefactor

EXHIBIT H

Annual Report
Trauma and Emergency Services 1/2013-12/2013 Report

ED Volume as of December 31, 2013: 3220 patients, Increased 7%compared to previous year.
ED Total Charges as of December 31, 2013: Decrease of 2.5% compared to previous year.

Dr. Diana Koelliker remains the Medical Director of Trauma and Emergency Services.
Dr. Simon Kotlyar started full time as an ED MD, July 1, 2013.
Dr. Peter Hackett retired this year but is still filling in as needed.
Dr. Daniel Hehir took over as the ED QA chairperson.

Policy and Procedures:

Policy and Procedures were reviewed. Several policies were updated to include the specific care of pediatric patients.

Affiliation with St Mary's:

SMH continues to supply blood to the ED. We have not used it this year.

New Equipment:

Neonatal/infant bed warmer

Staff Education:

ED staff was certified as Neonatal Resuscitation Providers. The half day training was held in the spring 2013. Instructors from St. Mary's Hospital certified staff for free as part of their outreach program.

General ED Updates:

ED MDs provided on-site coverage for the World Cup Snowboard Cross/PGS in December 2012. Without the medical support, this international event couldn't happen.

TMC received $5000 in funding from the WRETAC to hold a Certified Emergency Nurse Review Course June 9/10 2014. Montrose Memorial Hospital has offered to be the host site since it is centrally located for our region. The class will be offered to all emergency care providers in our region.

The ED is now sending ED encounter documentation to QHN to help improve the quality of patient care.

The ED is participating in meaningful use by reporting on PQRS measures.

The ED participated in the State's Pediatric Readiness Assessment which identified policies/procedures related to care of the pediatric patient that we could improve upon. This survey helped to identify supplies that could be added to our pediatric resuscitation cart to better care for these patients.

Alteplase was added to the formulary for care of patients with an acute stroke. Nurses were in-serviced regarding the administration of the medication. Pre-made packets include patient information regarding the use of this medicine, pre-administration checklists and physician orders.

Curosurf was added to the formulary and is rotated out with St. Mary's Hospital supply to prevent expiration. This is a surfactant given to premature infants to improve lung function.

A medication library was uploaded onto our IV pumps for emergency medications to help decrease medication administration errors.

Quality Assurance:

See separate QA report for details. Three quality initiatives were tracked this year, which included documenting patient temperatures, vital sign documentation after interventions and prior to transfer, pain level assessment on arrival and after interventions.

Annual ED QA Report January 2013 to December 2013

1. The QA process remained the same. Baseline criteria for reviewing charts includes: all transferred patients, deaths in the ED and unexpected returns within 72 hours. Findings, recommendations and actions are communicated to the staff to improve performance and implement changes as well as to communicate areas of excellence. Dan Hehir took over as the QA Chairperson in January 2013.
2. The ED has monthly QA meetings except for bi-monthly meetings during the off-season. 81 Trauma cases were reviewed. 94 Medical cases were reviewed. Charts are reviewed for quality of care as well as completeness of documentation/billing.
3. Synopsis of Trauma Cases:
    a. MDs were reminded to chart appropriately to justify level of care billed.
    b. Procedural Sedation Flow-sheet simplified to 1 page with improved documentation flow.
    c. After participating in the Pediatric Readiness Assessment by the State, several pediatric specific items for improved care were added that included having kid's books available, age appropriate shows/games for distraction on IPAD, "Buzzy Bee" for more comfortable IV sticks.
4. Synopsis of Medical Cases:
    a. Nurses were monitored for their complete documentation of vital signs as appropriate, pain assessment and intervention and temperature documentation.
    b. TMC continues to work with MMH regarding unnecessary ED visits vs direct admissions.
    c. Through QA process, it was determined the ACS checklist could be updated to be more user friendly.

Exhibit I

ANNUAL PRIMARY CARE REPORT
2013

Primary Care had a banner year.
PC Volume as of 12/31/13: 13,572 up 5 % from previous year .weeks.
PC Charges as of 12/31/13: Up 5% over last year.

Policy and Procedures:

All policies and procedure were reviewed with no change to existing. New policies relating to colonoscopy and mammogram referral and reporting in eCW were implemented. As part of CPCI Milestones a policy was created relating to notification of patients seen in TMC and other Emergency Departments ensuring appropriate follow up.

Electronic Health Record (EHR):

Primary care continues to utilize eCW as their electronic health record (EMR). Dr. Grundy, Eric Johnson and Cheryl Fitzhugh attended the eCW annual user's conference for third year. This has proved invaluable in enabling us to achieve Meaningful Use for the third year. These conferences have also helped us to more fully and efficiently use eCW to improve patient care. We anticipate an upgrade to eCW version 10 in the spring of 2014. This upgrade will facilitate continued participation in the Comprehensive Primary Care Initiative (CPCI) and reporting on Meaningful Use 2 in 2014 and to work towards certification as a Level III Patient Centered Medical Home (PCMH).

Meaningful Use:

As noted above PC attested for Meaningful Use at the end of 2011 and 2012. This resulted in additional payments from CMS of $56,000. MU payment for 2013 is anticipated to be $24,000. As a review, MU is a series of required and optional measures mandated by CMS in order to qualify for a Medicare reimbursement bonus in 2012 and beyond and to avoid penalties in 2014. At the end of 2013 we have met the requirements to attest for MU for the entire year, which will again result in a bonus payment from CMS. Meaningful Use 2 begins in 2014 (this has been delayed a year), based on our experience with MU 1, PC is well poised for success.

General PC Updates:

This is PC's 35rd year of existence and PC continues to grow and prosper financially. A primary reason for PC's continued success is the longevity of its staff and providers. As of 2013, Dr Gaylord has been at TMC for 17 years, Eric Johnson, 16 years, Laura Cattell, 13 years and Dr. Grundy, 12 years. This has provided PC Pt's with continuity of care that is unusual in rural settings. All providers remain board-certified in their specialties.

In May of 2013 Dr. Heather Linder, a board certified Family Practice Physician was hired to facilitate the need for increased provider coverage. Over the last few years Primary Care has seen significant increase in patient visits. Previous provider staffing had proved inadequate to provide the level of service needed and expected by the PC patient population. PC has committed to staffing three providers daily Mon. to Fri. in order to accommodate same day appointment needs and ensure that patients are seen in the appropriate department.

TMC PC remains a Vaccine for Children (VFC) provider, recently passing its annual inspection. This program allows PC to provide no cost immunizations to persons without insurance and for Medicaid Pt's. PC also continues to participate in the Colorado Immunization Information System (CIIS). Pt's immunizations are inputted into CIIS allowing for providers around the state to access individual PT records. It is anticipated that in 2014, with the implementation of eCW Version 10, that an interface between CIIS and eCW will finally become functional eliminating double entry of immunizations. This has been a slow process industry wise, but we are hoping this will come to fruition this year

The past year saw continued success of TMC's two most important community outreach programs; May Health Month and the October Health Fair. All TMC providers are providing community outreach and education through weekly Medical Moments.

PC, under the direction of Dr. Gaylord, recertified as a Pediatric Medical Home (PMH) in 2012. This benefited pediatric Pt's with increased services and benefits PC with increased reimbursement from Medicaid. Due to implementation of the Affordable Care Act, our participation as a PMH has qualified PC for Medicaid reimbursement equal to Medicare rates. This continues to be an approximate 37% increase over previous years.

PC discontinued aesthetic services beginning in early 2013 due to time constraints and little real financial benefit to PC.

<u>Quality Assurance/Quality Improvement</u>

The Primary Care staff held monthly Quality Assurance (QA) meetings eleven out of the last 12 months. There were a total of 4 charts per provider, per month reviewed during this period. A specific topic was chosen each month and a presentation on that topic was given by one of the provider's. Generally the physicians reviewed the Mid-level charts and vice versa.

In general the charting by all providers was comprehensive and patient care was appropriate with no major issues identified. The overall quality and thoroughness of charting continues to improve from year to year. Much of this can be contributed to the provider's increased familiarity with ECW and the development of specific templates and treatment plans and the QA process.

Primary Care has established both diabetic and Cardiovascular Disease (CVD) registries in 2102. The diabetic registry is well established and is showing result in improved patient compliance with care and improved measures of diabetic control. The cardiovascular disease registry is now well established and like the diabetic registry is resulting in improved patient care and outcomes. The Asthma registry was initiated in late 2013.

Paula Schiedegger transitioned form a medical assistant to a Care Coordinator. In this role she is managing the disease registries and meeting monthly with all providers to review the care needs for their patients in the registries.

Comprehensive Primary Care Initiative

In October of 2012 the Primary Care was chosen to participate in the CPCI. We are only one of 535 practices in the nation chosen for this program. This program is a creation of CMS and numerous private insurers. Fundamentally this program is a pilot effort to change the way health care is delivered in the U.S. CMS and other insurers will fund practices to create and maintain patient registries, create patient centered quality improvement projects, (to improve outcomes in chronic disease) and to identify and engage patients in a team centered approach to care.

At the end of 2013 Primary Care met and reported on all required CPCI milestones and has begun work on the 2014 milestones as well. PC's participation in this program has improved patient care and provide PC with $107,000 of additional revenue

Patient Centered Medical Home

PC had committed to pursuing certification as a PCMH in 2013. Due to the increased demands of the CPCI program, this was not feasible. This will be pursued in 2014.

Respectfully,

Eric C. Johnson, MS, CFNP-BC

Exhibit J

2013 Radiology Department Report

Staffing

The Radiology department is staffed with 3 full-time ARRT/CT registered radiologic technologists that share 24 hour, 365 day a year x-ray and Cat Scan coverage. There is one PRN ARRT/CT registered technologist that fills in for vacations and assists in high volume months. We are staffed with one ARRT PRN ultrasound technologist that covers one day every other week for routine ultrasound exams and one PRN echocardiography technologist that works one day every other week. For radiology and CT most shifts are covered by one technologist that performs both CT and X-ray exams with the occasional exception when 2 technologists cover the day shift during high volume days. All CT staff are CT certified. All of our staff with the exception of one lives out of the area. This requires on-call quarters for those staff members and limits availability in disaster situations.

Equipment

X-ray Room- GE Proteus x-ray unit that includes a floating tabletop and an upright bucky. This replacement unit was installed in November of 2005. In November of this year our Konica CR system was replaced with a Konica Aero DR unit and a tabletop CR unit for our portable machine. This allows us direct capture imaging which will improve efficiency and lowers the radiation dose to the patient and the CR unit will provide redundancy which we did not have in the past. The images are then stored off-site with Dell/In-Site One which stores all our images in two locations. They are also maintained on a local hard drive for a short period of time. The images can be retrieved realtime from In-site One for a period of 3 years and with a slight delay for older exams. We have 5 viewing stations using e-film, ultragateway and clear canvas software providing us with redundancy in case of equipment outages and allows easier access for providers and patients. We have an IPAD in the ER which allows us to show patients their images bedside. This year we added a PACS component to our Dell In-Site One storage which will allow visiting specialists and outside physicians access to our images via an internet website.

CT Room- GE Hispeed CT Scanner was replaced in November of 2008 with a 16 slice GE Brightspeed. A Medrad high pressure injector is used in conjunction with the CT scanner. These images are viewed on either the Primary, Secondary, Ultragateway or Ortho viewing stations and are stored with Insite-One. The Brightspeed scanner allows faster scanning times with more coverage, produces higher quality images and affords us angiography capacity that was not available with the Highspeed scanner. Our CT Accreditation from ACR for our CT scanner expires in July 2014. This was a requirement for Medicare billing starting January 2012.

Portable X-ray Unit- GE AMX 4 Plus. This unit was purchased in July of 2000 and is used in the ER for patients that are unable to leave the ER due to patient condition. Images are processed and stored same as conventional x-ray unit.

Mini C-Arm- Our Premier Fluoroscan Mini C-arm was traded in for a new OrthoScan Mini C-Arm. This unit was purchased March 2012 giving us improved fluoroscopy capabilities. Patient care has improved by allowing real time imaging while reducing

fractures or injecting joints while providing lower radiation levels and improved images. This new unit also maintains radiation dose amounts which is a state requirement. This has decreased patient time in the ER and the need for multiple x-rays to check alignment. Images can be stored on the hard drive or printed from the thermal printed connected to the system or saved to a USB drive.

GE Logiq I Ultrasound- This unit was purchased in February of 2008 and gave us the ability for the first time to perform ultrasound exams at this facility. There is a registered ultrasonographer scheduled one day every other week to perform scheduled exams along with one technologist that works every other week performing echocardiography. This unit is also used by the ER physicians for emergency patients. The images are stored with In-site One and can be viewed on the Primary, Secondary, Ultragateway and Ortho viewing stations.

Over Reads

Western Colorado Radiology Associates provide professional reading services for all x-ray and CT exams with exception of the x-rays taken for the visiting orthopedic doctors. The images are sent electronically at the time of exam via a VPN connection to St. Mary's Hospital where they are read and then a report is faxed back to Telluride Medical Center and this report is attached to the patient's medical record and routed to the referring provider for review. CT exams that are done after 11PM are transmitted to Virtual Radiology Service where they are read and a report is faxed back. The films are reread the next day by WCRA at St. Mary's Hospital in Grand Junction. Ultrasound exams are read by Virtual Radiologic and reports are faxed to the facility within 24 hours. These exams are also sent via a VPN highspeed connection. Echocardiology images are done and read by Dr. Johnson, Cardiologist in Frisco, Co. These images are mailed on a CD to his office and a report is faxed back to the Medical Center attached to the patient's medical record and routed to the referring physician for review.

VPN Connections

We have the ability to send images via a vpn connection to St. Mary's Hospital, Montrose Memorial Hospital, Virtual Radiologic, In-Site One and Swedish Hospital in Denver. We also have the ability to send jpeg images via encrypted e-mail. With the addition of our web based PACS viewer physicians anywhere in the world can be given access to our images.

Interfaces- We implemented an interface with QHN (Quality Health Network) and our EHR (Eclinicalworks) in 2012. This allows us to receive diagnostic imaging reports electronically from all western slope facilities which then allows web enabled patients to receive these reports via our web portal.

Supplies- Through our relationship with St. Mary's Hospital we are now part of Premier's GPO which helped to reduce our supply cost's this year.

Procedures-

Please find an attached spreadsheet demonstrating number of procedures and revenue generated for Jan-Dec 2013.

EXHIBIT K

Telluride Medical Center
Annual Pharmacy Summary 2013

The Telluride Hospital District d.b.a. Telluride Medical Center (TMC) is authorized and licensed by the State of Colorado; Department of Public Health and Environment to engage in business as a Community Clinic and Emergency Center. The State of Colorado; Department of Public Health and Environment has designated TMC as a Level V Trauma Center. These designations allow TMC to provide the most extensive care in the area and requires an adequate pharmacy. The Colorado State Board of Pharmacy granted TMC an Other Outlet license in October of 2006. New protocols for the pharmacy were updated in 2012. The pharmacy is inspected monthly by our consultant pharmacist Mark Wantenpaugh R. Ph. and annually by the Colorado State Board of Pharmacy. Class II Narcotic inventory is done yearly, RN's perform a count daily to ensure safe dispensing practices. The Sample Medication Log is reviewed regularly and a monthly review of medications is performed by an RN to insure all expired medications are removed from the sample cabinets. The log is reviewed and noted to be up to date.

The TMC Pharmacy was inspected by Mark Wantenpaugh, R.Ph., consultant pharmacist monthly in 2013 with no deficiencies noted. The state of Colorado now requires us to report the number of prescriptions filled from our pharmacy. If less than 2500 yearly, we are required to have monthly inspections by our pharmacy consultant. Our average last year was 539 prescriptions dispensed. This decreased from 820 the prior year, and is most likely due to Apotheca pharmacy being available for sales on the weekend. The Colorado State Board of Pharmacy performed an Other Drug Outlet Inspection on 07/09/2013. Minimal deficiencies were noted, the inspector was unable to locate the log (I was not working that day) and the pharmacist was unavailable one of the months. This was remedied by placing the yearly prescription dispensing log at the front of the pharmacy inspection notebook. Mark Wantenpaugh and I will coordinate times for regular monthly visits.

The Medical Staff met in June of 2013 and a review was performed on all medications in the pharmacy. New medications were approved and several drugs were taken off the formulary after it was noted that some were redundant (other drugs we carried could do the same job) as well as some not being used regularly, as noted by regular inventory checks. This greatly helps to decrease costs. The Medical Staff reviews all medications dispensed through the TMC pharmacy and insures that the most current/standard of care medications are available for the Emergency Physicians to utilize for our patients; as well as appropriate medications to dispense to patients seen outside of the local pharmacy hours.

Two new medications we acquired include Activase (tPA) and Curosurof (Surfactant). Our 1st dose of Activase was generously donated by a donor via the Telluride Foundation. Our cost for this item is approximately $2,800. Activase is most frequently used for management of acute ischemic CVA's (cerebrovascular accidents or stroke). Activase (tPA) works on the bodies clotting system to break down clots and if given within 3 hours of the onset of symptoms to qualified patients, can greatly decrease disability and even death. Activase is manufactured by Genentech, and we are able to return the medication to them prior to expiration and receive a

replacement at no charge. Curosurof (Surfactant) is an important drug used for management of premature infants with complications due to lung immaturity. Surfactant reduces surface tension in the alveoli (microscopic air sacs) of the lungs. This helps to keep the alveoli inflated and prevent respiratory distress syndrome. We have an agreement with St. Mary's hospital pharmacy to keep this drug on hand, and returning 6 months prior to expiration without charge to our facility. We are only charged for this drug (approximately $650.00) if and when we use this. These drugs were added to the formulary because of our remote location and time to definitive care, and the increased survival rates associated with them.

We are now contracted with Premier/Adventist, a PPO buying group in which we receive substantial discounts on pharmaceuticals and now immunizations. We are also now contracted with the Cardinal Health Pharma hospital account. This is now our primary supplier as they contract with Premier/Adventis. Availability of medications is much better, although national pharmaceutical back orders and shortages remain a problem. I generally try to order medications through Cardinal Health, but many times do not because they require purchase of cases versus medications by the each. Our other suppliers include Boundtree Medical, APP pharmaceuticals direct, Sunshine Pharmacy and Apotheca. Both Montrose Memorial Hospital and St. Mary's Hospital are very easy to work with and will supply medications to us if there are no other options. Larger packaging requirements account for a larger amount of returns. We return medications through Guaranteed Returns in which were are reimbursed for a small portion of the expired medications we return. This company safely dispenses expired medications for us.

The pharmacy manager organizes and maintains the inventory of all medications and performs bimonthly checks in the main pharmacy, ED pharmacy cabinet, code cart and all refrigerated medications in the ED and main refrigerator for expirations. Daily temperatures are recorded on all refrigerators to insure safe storage. Our formulary is updated regularly, and now contains 210 medications for use in the ED and Primary Care. Medications are ordered weekly to meet established minimum par levels, with several hours per shift and time at home spent obtaining the most rapidly available and cost effective medications. The pharmacy manager also monitors the State and Federal licensure of the Other Outlet Pharmacy. Licensure is renewed every 1 – 2 years through the Colorado State Department of Regulatory Agencies (DORA) and the DEA. Suppliers also require current licensure to be provided to them. A yearly inventory is performed for accounting purposes. This spring a new ED refrigerator with an internal temperature sensor was purchased when the 15+ year old refrigerator became inconsistent.

Respectively submitted,
Betsy Muennich R.N., B.S.N., ED Nurse; Pharmacy Manager

Exhibit L

Telluride Medical Center
Annual Laboratory Summary
2013

The Telluride Medical Center (TMC) operates a CLIA certified moderate complexity laboratory under a Certificate of Compliance from the Centers for Medicare and Medicaid Services. The current certificate expires 6/17/14.

The Laboratory underwent an inspection by the Colorado Department of Public Health on Dec. 19th, 2013. This survey resulted in no reportable deficiencies and was found to be compliant with all requirements. The next inspection is anticipated to occur in the fall of 2015

The Medical Center laboratory continues provide some sophisticated "in-house" lab services that include, CBC with differential utilizing an ABX Horibas Micros 60 hematology analyzer and blood chemistry utilizing an Abbott I-Stat chemistry analyzer. The lab also uses several point of care "quick" tests including, group A beta Strep, influenza A+B, mononucleosis, urine pregnancy, d-Dimer, urine dip, and quantitative cardiac enzymes. Many of these "quick" tests are CLIA waived requiring no proficiency testing.

As of late in 2009 I-Stat chemistry testing has become CLIA waived and proficiency testing on specific cartridges will no longer performed. This results in continued year to year savings on testing costs from American Proficiency Institute (API).

In early October of 2010 an Abaxis Piccolo chemistry analyzer was brought on line. The staff is now well versed in its usage. This instrument allows a broader range of testing than the current I-Stat analyzer. New tests include a Liver Panel Plus which will prove invaluable in treating patients with abdominal pain and may save a trip to Montrose just for laboratory testing. Additionally a Basic Metabolic Panel which includes a CO2 will give providers more information than the current I-Stat chemistry panel.

The I-Stat analyzer will still remain in service to perform Troponin and PT/INR testing. A new I-Stat was brought on line in May of 2011 to provide more efficiency and timely lab results.

The original Horibas Micros 60 analyzer was replaced early in 2012 thanks to a generous grant from the Telluride Medical Cent Foundation. The original unit had reached its useful lifespan. This has resulted in less work for the staff troubleshooting, cleaning and repairing the instrument and continues to provide high quality testing results.

The TMC lab contracts with the American Proficiency Institute for annual proficiency testing samples. Results are transmitted and received electronically and reviewed by the Lab Director and/or designee. Corrective action is initiated if indicated. As of the end of 2013, the lab is

successful in all testing. Daily and monthly controls are performed per protocol and reviewed for accuracy at regular intervals by the laboratory director or designee.

Reference laboratory services are provided to Telluride Medical Center patients by LabCorp. Specimens are transported by courier, Monday through Friday, to Grand Junction and then flown to Denver. Results are received electronically directly into the patient record. Receipt of labs is monitored weekly by designated staff members to assure quality.

Respectively submitted

Eric C. Johnson, MS, CFNP
Primary Care Practice Manager

EXHIBIT M

Telluride Medical Center
Medical Staff Annual Report
Daniel Hehir, MD
Chief of Medical Staff

In 2013 the Medical Staff approved the credentialing of Dr. Kotlyar in the Emergency Department and Dr. Linder in the primary care. Also Drs. Colwell, Johanson, Jackson, Machi, Gates, Harlow, and Kueber were credentialed as visiting residents.

Dr. Hehir has been creating a privilege delineation description for all of the provider specialties at TMC. Primary Care and Emergency Department privilege delineation forms have been completed and approved by the Telluride Hospital District board. Privilege delineation forms are pending for the visiting specialists as of the first of the year.

2013 is an off year for recredentialing for the entire institution. This will be again completed in 2014 for all providers. Procedural changes for this year include having each provider sign off on the Medical Staff Bylaws, signing their specialty appropriate privilege delineation, and specifically credentialing providers for their medical staff category (i.e., active vs. locums tenens or consulting staff etc.).

The Medical Staff Bylaws were reviewed and changes were approved by the medical staff and the TMC Board of Directors.

The TMC formulary continues to be updated on a biannual and a PRN basis. This is necessary to keep pace with the changing availability of medications, as well as continuing to maintain a cost effective pharmacy balancing to need to keep necessary medications in stock. Availability of medications in the United States continues to be an ongoing issue and we continue to struggle with acquiring important medications as our stock expires.

Ongoing discussions regarding the addition of visiting specialists continue. It is the goal of the medical staff to provide for specialist services to serve our community with the understanding that their presence cannot hinder the efficiency of our Primary Care and Emergency Services. It is agreed upon by the medical staff that we are at our available capacity for visiting specialists and careful consideration would be needed before the addition of any new staff.

TELLURIDE FOUNDATION

Telluride Health and Wellness Center Initiative

Final Report

January 2014

Contents

220 E. Colorado Avenue, Suite 106, PO Box 4222 Telluride, CO 81435 **970 728 8717** fax 970 728 9007
www.telluridefoundation.org

I. Executive Summary

The objectives of the Health & Wellness Facility Initiative were to:

1) Re-affirm the need for new Telluride Medical Center (TMC) facility
2) Investigate interest from other providers to enter and expand in the market
3) Analyze four available parcels of land for a new medical facility
4) Investigate a "developer financed" facility model

Three expert firms were hired to assist with meeting the above objectives, including

1) Halsa Advisors (http://halsaadvisors.com)–a facilities advisory firm to analyze programming and potential provider interest
2) Frauenshuh (http://frauenshuh.com) – healthcare facility real estate developers to analyze potential parcels of land
3) Engaged Public (http://www.engagedpublic.com) – public engagement firm to collect public input

Three sites emerged as feasible to develop, which were supported by the listed stakeholders

1) Telluride RV parcel
   i) Telluride Hospital District (THD) and Town of Telluride
2) Society Turn parcel
   ii) THD, Telluride Fire District/Emergency Medical Services (EMS), San Miguel County and private landowner
3) MV parcel
   iii) THD and Town of Mountain Village

The concept of a developer financed/market driven facility was validated; key validation points included that:

1) A new facility could meet sq. ft. market rents
2) There was additional provider interest in entering or expanding in Telluride market
3) Opportunities for expanded integrated health and healthcare delivery existed

Two business models emerged from the analysis process:

1) A market driven/developer financed option – financed by developer with stakeholder governance
2) A public financed option with a voter referendum led by the Telluride Hospital District.

This report summarizes the consultants' findings and provides a business model and a comparison of the three sites.

Next Steps include:

1) Setting a timeline for new facility development
2) Creating a site RFP to determine entitlements and acquisitions costs
3) Forming a new governance structure if the non-public financed option is pursued

A special thanks goes out to the donors, executive committee, and community council members for their time, resources and leadership.

II. Background and Guiding Principle

Project Scope

The objective of the Telluride Health and Wellness Center Project is to explore the public, developer and healthcare provider interest in expanding and consolidating local healthcare, health and wellness services through construction of a financially self-sustaining healthcare facility or campus.

This will be accomplished through a combination of:

- Actively engaging the public on attitudes, needs and suggestions.
- Soliciting advice and feedback from a group of community leaders.
- Conducting a parcel analysis by a qualified healthcare real estate developer.
- Conducting a healthcare services market analysis by a qualified healthcare consulting firm that will identify both opportunities for and interest among selected healthcare providers in delivering additional health and wellness services and under what conditions.
- Securing sufficient funding to finance this phase of the project.
- Make an analysis of the financial sustainability of additional or expanded services.
- Evaluate and determine the viability partnering with a qualified developer to build and finance the facility.

The deliverable from the project will be a determination on the viability of a sustainable business plan that partners with a qualified developer, and, if appropriate, selection of a developer and formation of the governance structure for the next stage of the project.

Guiding Principles

1) Genuine and active public participation is vital to determining the community's health and wellness needs now and into the future.

2) The medical center needs a new facility given its current facility's age, location and space and licensing constraints and to meet the burgeoning demand, changing patient needs, and variety of future health care models.

3) An opportunity may exist to expand the scope of healthcare services offered in the Telluride region based on a suitable site and a sustainable business plan. Additional services not presently available could be included in a facility and/or campus, providing costs savings and regional economic development.

4) Limited sites in Telluride, Mountain Village and Society Turn are available that should be evaluated, as they may be suitable for the current and expanded facility needs.

5) Plans should be developed that will avoid additional district tax levies, and the facility should be financially self-sustaining.

III. Charter

Roles and Responsibilities

Executive Committee

- The Executive Committee is responsible for managing and directing all aspects of this project.
- The Executive Committee shall utilize any funds raised specifically for this project to obtain advice and services from independent consultants and other experts.
- At the conclusion of this project the Executive Committee shall be responsible for producing a report including findings and recommendations.
- The Executive Committee consists of four members: Bill Grun, John Pryor, Davis Fansler and Paul Major, all of whom bring a good balance of skills, geographic representation, local knowledge and experience, healthcare knowledge, and business acumen.

Community Council

- The Community Council is responsible for providing on-going advice and feedback to the Executive Committee regarding the project in order to help serve as a communications link between the project and the community.
- The Executive Committee will hold periodic meetings with the Community Council to keep them informed and to solicit their feedback.
- The Community Council will be selected by the Executive Committee to represent a broad spectrum of the community including homeowners, second homeowners, business owners, local healthcare services, local leaders and other community members.
- The role of the Community Council is advisory only. Members will be expected to be knowledgeable about project material and information, attend meetings in person or by telephone, provide feedback to the Executive Committee, and to serve as an accurate source of project information to the community.

Telluride Foundation

- The Telluride Foundation is the facilitator of this project. It will provide administrative, organizational, and accounting support as well as the legal structure to allow charitable contributions to fund the project, and to contract for the services of consultants.
- The Telluride Foundation has contributed the services of Paul Major and an assistant to this project.
- The Telluride Foundation is not responsible for directing or funding this project, or for the findings and recommendations of this project.

Telluride Medical Center

- The Telluride Medical Center has provided information to this project regarding past analyses related to forecasted regional demand for various medical services as well as information related to TMC's own new facility requirements and potential local building sites.
- The Telluride Medical Center will collaborate with the Executive Committee to review potential building sites and other facility related issues to help ensure that any potential recommendations fully consider TMC's requirements.
- Telluride Medical Center Foundation**:** The Telluride Medical Center Foundation has contributed the services of Kate Wadley to help raise money specifically for this project.

IV. Community Council Members

- Ron Allred - former developer and owner, Telluride Ski & Golf Resort
- Michael Armstrong – second homeowner; chairman of the board of trustees of Johns Hopkins Medicine, the Johns Hopkins Health System, and the Johns Hopkins Hospital
- Lynn Borup - Executive Director, Tri-County Health Network
- Chris Chaffin - Principle, ChaffinLight
- Dylan Brooks – local business owner, Lawson Hill resident
- Davis Fansler – Former Mayor of Mountain Village; Director, Health Care Practice, Wipfli LLP
- Stu Fraser - Mayor, Town of Telluride
- Ginny Gordon - local business owner
- Bill Grun – Chair, Telluride Hospital District Board
- Dr. Sharon Grundy - Medical director, Telluride Medical Center
- Paul Hobby - second homeowner; chair Baylor Medical System
- Dan Jansen - Mayor, Town of Mountain Village
- Dr. Diane Koelliker - Emergency Department Director, Telluride Medical Center
- Larry Mallard - local business owner and TMC Board member
- Paul Major – President and CEO, Telluride Foundation
- Joan May - County Commissioner, San Miguel County
- Melissa Plantz - local business owner
- John Pryor – Former Mayor of Telluride; Principal, Telluride Venture Partners, LLC, Oakland Hospital LLC
- TD Smith - Managing Director, Telluride Real Estate Corporation

Health & Wellness Center Site and Business Plan Comparisons

1/10/2014

	Developer Financed			Publicly Financed
Location	**Society Turn**	**MV 1007-1008**	**Telluride RV Lot**	
Business Plan	Market driven	Market driven	Market driven	Publicly Subsidized
Construction	Developer led	Developer led	Developer led	THD Led
Ownership	Developer/ Investors	Developer	Developer	THD
Structure Size	40k SF (plus 20K SF EMS)	40K SF	21K SF	30K SF
Operating model	Integrated and expanded health services	TMC Comm Clinic and ER with limited specialty/ procedures	TMC Comm Clinic and ER with limited specialty/ procedures	TMC Comm Clinic and ER with limited specialty/ procedures
Affiliation (Baylor or other)	Yes	Possible	Possible	Possible
Specialty services	Expanded, centralized, integrated	Limited, integrated	Limited, integrated	Limited, integrated
Wellness opportunity	Yes	No	No	No
Est Construction Cost (Per GSF)	$17M	$17M	$14M	$20M
Financing (est.)	Developer Financed	Developer Financed	Developer Financed	Publicly Financed
Developer	$10M	$17M	$10M	NA
Tax	NA	NA	NA	$16M
Charitable	$7M	?	$4M	$4M
Other	Newmont lease buyout	Town of MV; Newmont lease buyout	Newmont lease buyout	Newmont lease buyout
Public vote	No	No	No	Yes
Anchor Tenants	TMC and EMS	TMC	TMC	TMC
Occupancy Costs				
TMC	$300K/year	$300K/year	$300K/year	None
EMS	TBD	NA	NA	NA
Other tenants	$40/GSF	$40/GSF	NA	TBD
Site Development Costs	TBD	TBD	TBD	TBD
Land Acquisition Costs	TBD	TBD	TBD	TBD
Adjacent heli pad	Ground	Roof top	Roof top	Roof top
Adjacent Parking	Yes	Yes	Limited	Limited
Expansion	Yes	No	No	No
Regional Economic Impact	Incremental Increase	Current	Current	Current
Service leakage	Lesser	Status quo	Status quo	Status quo
Meet Healthcare Trends (ACA)	Greater	Static	Static	Static
Internal Stakeholders	Private land owner, County, TMC and EMS	Town of Mountain Village and TMC	Town of Telluride and TMC	Town of Telluride, TMC and Public

Telluride Health & Wellness Facility

Update - September 16, 2013

The Status

We're at a substantive point in the information and analysis process with extensive provider market information, thorough parcel analysis and broad public input.

With the help of consultants, we're going through an interactive process of determining:

- the local and regional health and medical provider interest to service our market
- what the tenant cost per sq. foot might look like in a new facility
- the suitability of various parcels of land in terms of access, zoning, etc…
- developer ability to bring product to market
- public input

Key Question to Answer

Are there enough anchor tenants (market interest), in addition to TMC, and a suitable parcel of land, for a developer to build and finance a new facility?

This analysis specifically concerns the feasibility of a market driven/developer financed facility.

Guiding Funding Assumptions

Irrespective of the path it takes or the amount of available cash flow currently available to TMC, it will require substantial funding for a new facility for construction costs and/ or increased rental costs

- Sources are private (philanthropy, investor) and/ or public (mill levy, bond, etc.)
- Any investor (developer, bondholder) will require a ROI. Any mill levy increase will raise taxes
- Public sources to build a new facility have been pursued and failed; philanthropy is untested but has been generally understood as needed under some scenario's

Two Programming/Business Tracks Emerged

- "Retail" track:
  - TMC as anchor tenant
  - Other tenants include local PT, fitness, chiropractor, pharmacy, mental health, visiting specialists, etc…
  - Pedestrian access sensitive

- "Healthcare" track:
  - TMC and Fire/ Emergency Services as anchor tenants
  - Other tenants include pharmacy, mental health, visiting specialists, wellness, etc…
  - Airport and regional road access for ambulance

DRAFT

Master Program Framework

The following framework was developed to identify services that support the Health and Wellness vision and to provide a rationale for potential prioritization and/or phasing of the facility development..

Tier 1 Services Services that exist today and are currently located at TMC; our core Mission services	• Emergency Dept. • Primary Care Clinic • Radiology • Admin/Support
Tier 2 Services Services that currently exist in the community but that are in separate locations; potential to incorporate more integrally into Medical Home model; good potential for synergies	• Mental Health • Pharmacy • Physical Therapy • Complementary Medicine / Wellness • EMS • Helicopter Landing Zone
Tier 3 Services Services that do not currently exist in the community but that could be supported; impact to both operations and space	• Visiting Specialist Clinic • Overnight Beds / CAH Designation • Minor Procedures • MRI
Tier 4 Services Services that currently exist in the community but that are in separate locations; potential to include within "Health/Wellness Neighborhood" but limited synergies with other clinical services	• Dental Services • Orthodontics • EMS / Ambulance Facility • Fitness Center
Tier 5 Services Services that do not currently exist in the community but that could serve as a destination center of excellence; likely to require independent business plan and outside investors along with significant will to "pull" customers to Telluride	• High Altitude Training (ex. HYPO2) • Destination Wellness Center (ex. Andrew Weil Integrative Wellness Program, Tucson, Ariz., The Ranch at Live Oak, Malibu, CA) • Destination Program – Plastics, Ortho, other

DRAFT

Preliminary Master Program

Note: All indicated master program space requirements are in Departmental Gross Square Feet (DGSF); program numbers will likely need to be refined subsequent to tenant review of marketing package completed by Frauenshuh.

	Program Area	Program DGSF	Program Basis	Potential Tenant	Contact
Tier 1 Programs	**Telluride Medical Center**				
	Emergency Department	4,200	7 exam/treatment rooms		
	Imaging	1,800	Includes Rad, CT, U/S, EKG		
	Primary Care	5,400	peak 4 providers in clinic; 9 exam; incl. PFT, Stress		
	Altitude Medicine		Incl. in other spaces – PFT, Stress		
	Administration	1,400			
	Staff Quarters	1,400			
	Facility Support	2,200			
Tier 3 Programs	Visiting Specialist Clinic	1,000	2 exam rooms; leased to independent visiting specialists		
	Observation Beds	800	Two for Critical Access designation		
	Procedure Room	500			
	Mobile MRI		Provide access for mobile MRI		
	Helicopter Landing Zone		Site impact; proximate to ED		
	TMC Subtotal	18,700		Telluride Medical Center	Gordon Reichart
	Visiting Specialist Clinic	2,000	2 providers in clinic; 4 exam rooms	Montrose Medical Center	Mary Snyder, COO
Tier 2 Programs	**Mental Health Offices**	500		Midwest Mental Health	Jon Gordon
	Home Health	2,000		Sinfonia Health, other potential	Fletcher McCusker
	Pharmacy* **	1,800		Sunshine Pharmacy	Mark Watenpaugh
	Physical Therapy* **	2,500		Peak Performance, other potential	Mark Campbell
	Chiropractic	1,000		Adams Chiropractic Clinic, other potential	John Belka, DC
Tier 4 Program	**Fitness*** **	2,000		8750 ALT, other potential	Dennis Lankes
	Dentist	1,800		Telluride Dental	Dr. Grady, DDS
	Crossfit	5,000		Telluride Gymnastics & CrossFit	
	TOTAL	**37,300**			
Tier 5 Program	**Other Potential Programs**		Require further development		
	EMS/Ambulance Garage	20,000	Plug number per Davis Fansler and Paul Major	Telluride Fire Department	John Bennett
	High Altitude Training	TBD	Likely use of TMC diagnostics and partnering with other entities for accommodations and training facilities		
	Baylor	TBD	Potential collaboration in Ortho, Altitude Med, and Telemed		
	*** Denotes programs most sensitive to location; will likely not participate if located at Society Turn				

Parcel Evaluation Criteria

Score 1 -5 INFRASTRUCTURE/ACCESS TO UTILITIES & PARKING

Proximity and availability of required utilities in appropriate size/quantity to adequately serve immediate and future needs. Ability of the site to fulfill basic parking requirements for the facility.

Score 1 -5 SITE ACCESS/EMS/HELIPAD

Appropriate access for community members (pedestrian and vehicular), EMS vehicles and helicopter.

Score 1 -5 PARCEL AVAILABILITY/ENCUMBRANCES

Opportunity to align development parameters to allow for aggressive progress toward design and construction start.

Score 1 -5 APPROVAL PROCEDURES/TIMEFRAME

Required municipal stages of approval and associated timeline conducive to an aggressive development schedule.

Score 1 -5 FUTURE EXPANSION POSSIBILITIES

Opportunity for subject property to support additional construction or expanded specialties and services following initial program development.

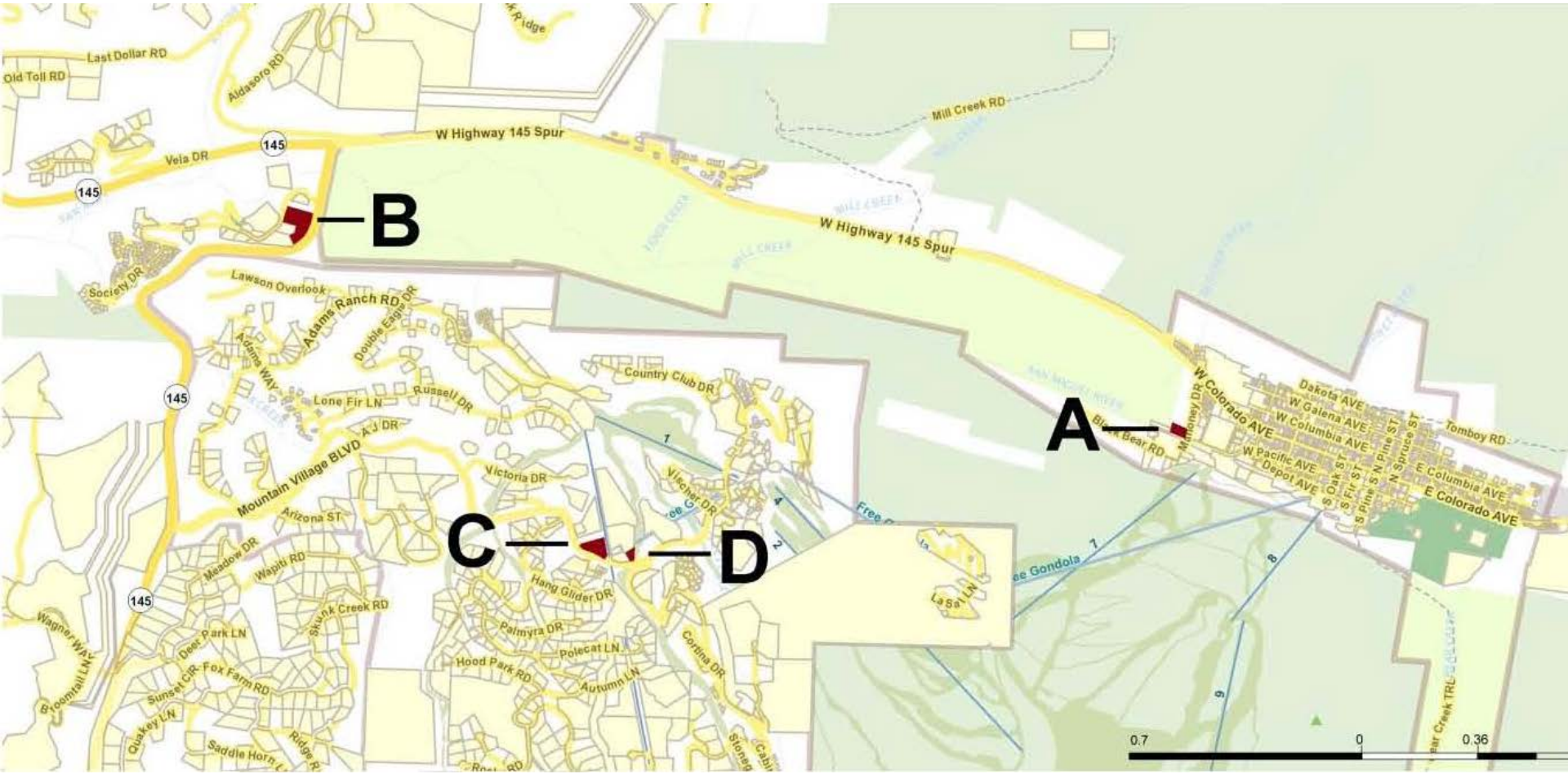
Score 1 -5 ADJACENCIES (PROGRAMMATIC)

Can clinical programmatic components be optimally located relative to the site and each other on/within the subject parcel?

Score 1 -5 SUSTAINABLE OPPORTUNITIES

Does the parcel possess the opportunity to foster green building principals utilizing specific exposures, green building systems and LEED principals?

Locations and Land Parcels



Parcel A - TOT

DRAWING NOT TO SCALE
BOUNDARY DIMENSIONS APPROXIMATE

Parcel B – Society Turn

Parcel C – MV 1007-1008

Parcel D – MV Town Hall

Initial Conclusions

A few initial conclusions emerged from Halsa (consultant analyzing potential service provider interest), Frauenshuh (consultant analyzing potential parcels of land) and the public.

- Programming adjacencies are critical to provider attractiveness. Meeting these adjacencies requires a minimum 17,000 sq.ft. ground floor.
- Adjacent helicopter access required.
- Adequate adjacent parking required (generally up to 5 spaces per 1000 SF).

Initial Conclusions

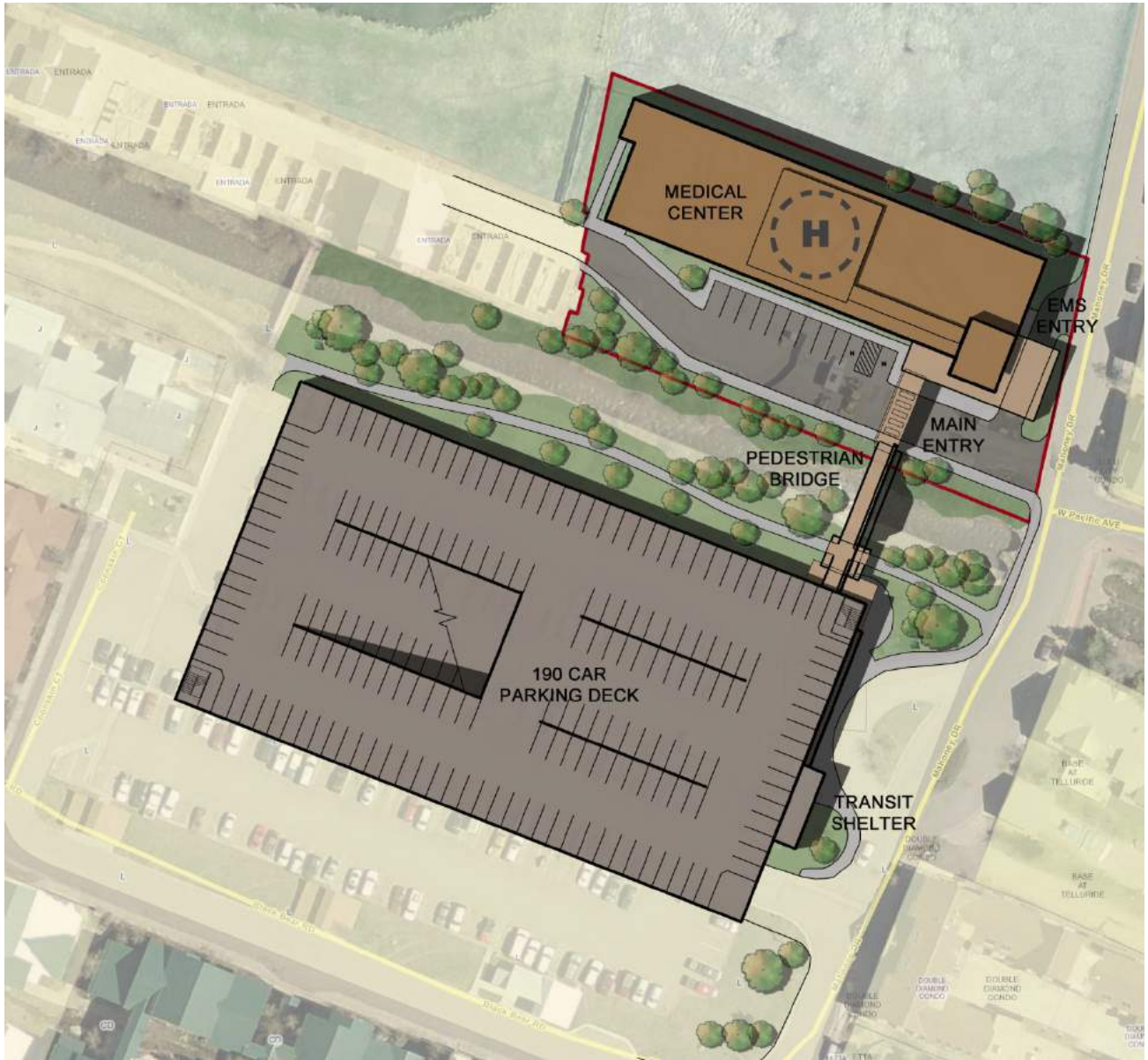
- Given the locations of the parcels, only a “Retail” track would make sense on the TOT and MV parcels and only a “Healthcare” track would make sense on the Society Turn parcel.
- Ensure market adjacency requirements are met that additional providers have indicated are essential for them.
- Ensure any specific site constraints are met in terms of building footprint.
- Ensure a reasonable rent/sq. ft. so that additional providers will be interested in participating.
- Ensure the developer’s return is sufficient that they are interested in building and/or financing the facility.

Initial Conclusions

- One of the MV parcels has a footprint that's too small to accommodate the required minimum ground floor programming.
  - Further TMV input is required on the other site
- Helicopter access could only be provided on the roof of the TOT and MV parcels while it could be provided on the ground at the Society Turn parcel.
  - Due to the structural building requirements for a rooftop helipad, this will increase building costs.
- Given its footprint and the parking requirements, the TOT and MV parcel requires an adjacent parking structure to be built.
  - This will result in an increase in building costs.
- Society Turn parcels' zoning allows a health/professional/office facility and will receive TOT water/sewer approval.
- Given the footprint requirements it is assumed at least a two story structure on all parcels will be required.

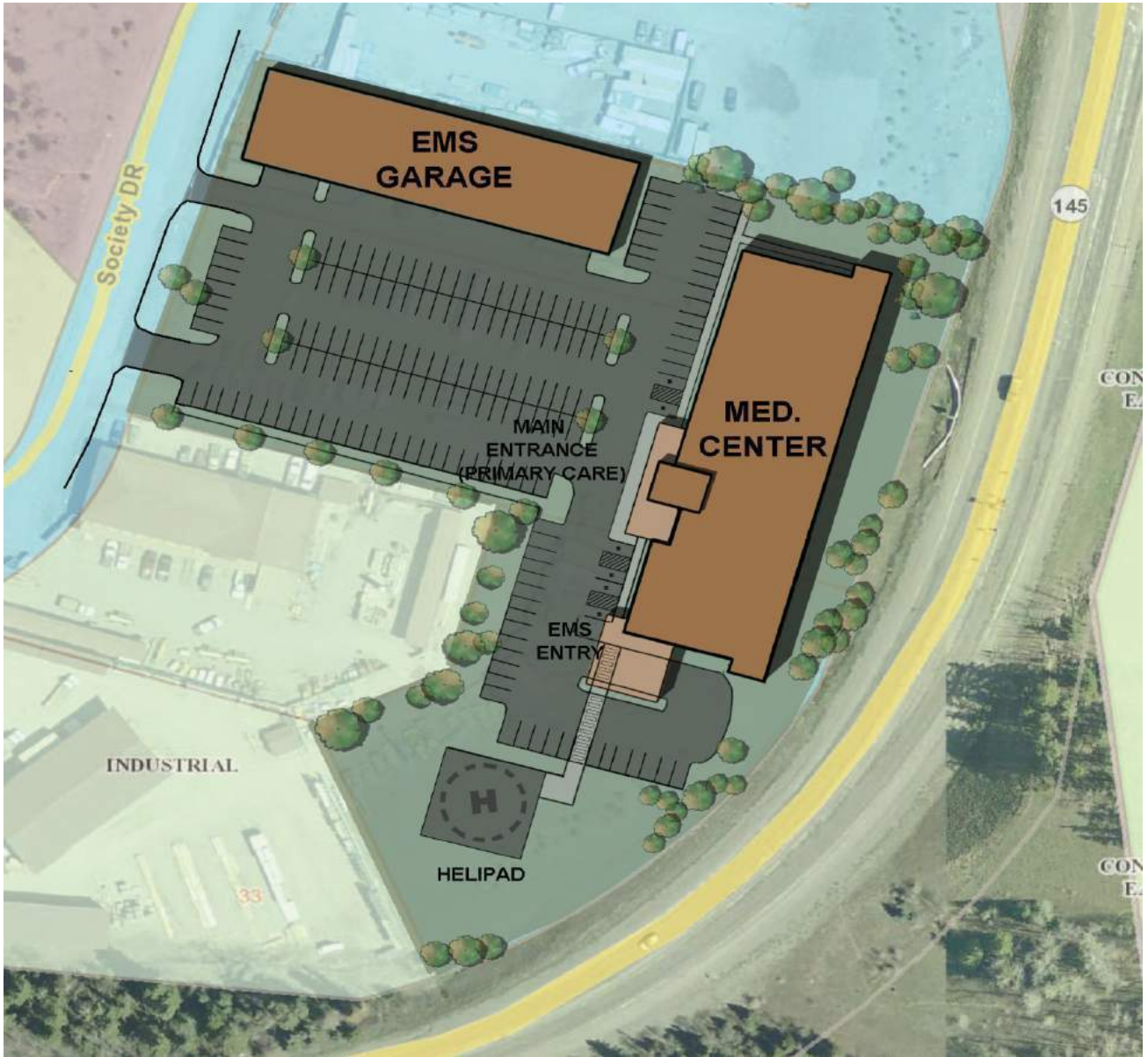
TOT Parcel

SITE AREA:	42,400 SF (APPROX.) – Medical Center Site only
MEDICAL CENTER STRUCTURE:	39,000 GROSS SQUARE FEET
	19,500 SF FOOTPRINT – 2 LEVELS
HELIPAD:	ROOFTOP
PARKING:	11 TOTAL PARKING SPACE ON SITE
	470 PARKING SPACES ON ADJACENT CITY LOT
	(280 SURFACE SPACES AND 190 CAR PARKING DECK)



Society Turn Parcel

SITE AREA:	180,770 SF (APPROX.)
MEDICAL CENTER STRUCTURE:	39,000 GROSS SQUARE FEET
	19,500 SF TMC FOOTPRINT – 2 LEVELS plus SEPARATE 15,000 SF EMS GARAGE
HELIPAD:	ON-GRADE
PARKING:	175 TOTAL PARKING SPACE



TOWN OF TELLURIDE SITE		
Size Assumption		
* Based on Preliminary Master Program provided by Halsa Advisors		
Telluride Medical Center	18,700	
Specialty & Expansion Tenants	19,300	
Total Rentable Square Feet	38,000	
Total Gross Square Feet	40,000	
Cost Assumptions		
Land:	$ -	
Building Cost:	$ 250.00	per gsf
Site Work:	$ 6.50	per gsf
Tenant Improvements ($35.00/ rsf):	$ 33.25	per gsf
Parking Structure:	$ 143.75	per gsf
Additional Hard Costs:	$ 15.42	per gsf
Soft Costs:	$ 35.28	per gsf
Development Overhead and Construction Interest:	$ 28.81	
Total Estimated Project Cost:	$ 513.00	per gsf
Vacancy Assumptions		
Year 1:	20.0%	
Stabilized:	5.0%	
Financing Assumptions		
LTV:	75.0%	
Interest Rate:	5.0%	
Term:	10	
Amortization:	20	
Year 1 Required Rents		
Net Rent:	$ 46.50	per rsf
Estimated Operating Expense:	$ 14.00	per rsf
Gross Rent:	$ 60.50	per rsf
Inflation Assumption:	2.0%	
Note:		
This analysis includes a 200 space parking structure with connecting bridge built over the lot adjacent to the proposed site. Net rent rates without the cost of this structure included would be **$31.75 psf**.		

SOCIETY TURN SITE		
Size Assumption		
* Based on Preliminary Master Program provided by Halsa Advisors		
Telluride Medical Center	18,700	
Specialty & Expansion Tenants	19,300	
Total Rentable Square Feet	38,000	
Total Gross Square Feet	40,000	
Cost Assumptions		
Land:	$ -	per gsf
Building Cost:	$ 200.00	per gsf
Site Work:	$ 5.00	per gsf
Tenant Improvements ($35.00/ rsf):	$ 33.25	per gsf
Parking Structure:	$ -	per gsf
Additional Hard Costs:	$ 9.56	per gsf
Soft Costs:	$ 33.58	per gsf
Development Overhead and Construction Interest:	$ 19.86	per gsf
Total Estimated Project Cost:	$ 301.25	per gsf
Vacancy Assumptions		
Year 1:	20.0%	
Stabilized:	5.0%	
Financing Assumptions		
LTV:	75.0%	
Interest Rate:	5.0%	
Term:	10	
Amortization:	20	
Year 1 Required Rents		
Net Rent:	$ 27.25	per rsf
Estimated Operating Expense:	$ 14.00	per rsf
Gross Rent:	$ 41.25	per rsf
Inflation Assumption:	2.0%	

EMS BUILDING AT SOCIETY TURN SITE		
Size Assumption		
EMS	20,000	
Total Rentable Square Feet	20,000	
Total Gross Square Feet	20,000	
Cost Assumptions		
Land:	$ -	per gsf
Building Cost:	$ 175.00	per gsf
Site Work:	$ 5.00	per gsf
Tenant Improvements ($35.00/ rsf):	$ 8.75	per gsf
Parking Structure:	$ -	per gsf
Additional Hard Costs:	$ 10.49	per gsf
Soft Costs:	$ 28.98	per gsf
Development Overhead and Construction Interest:	$ 15.35	
Total Estimated Project Cost:	$ 243.57	per gsf
Vacancy Assumptions		
Year 1:	20.0%	
Stabilized:	5.0%	
Financing Assumptions		
LTV:	75.0%	
Interest Rate:	5.0%	
Term:	10	
Amortization:	20	
Year 1 Required Rents		
Net Rent:	$ 18.75	per rsf
Estimated Operating Expense:	$ 12.00	per rsf
Gross Rent:	$ 30.75	per rsf
Inflation Assumption:	2.0%	
Note:		
Tenant improvements are calculated on 25% of the rentable square feet. This assumes a 75/25 split between garage and office space for EMS.		

Emerging Developments/Next Steps

- Baylor College of Medicine in Houston has indicated interest in working with us to establish:
  - Telemedicine for specialty and sub-specialty
  - Affiliation and “branding” association

- TOT parcel zoning will be put to a public vote in November. The vote would allow zoning for development that could include a medical facility.

- Fire & EMS team has indicated interest in locating their services with a new medical facility at Society Turn, assuming their space/access requirements are met.

Emerging Developments/Next Steps

- We need to engage the public in terms of the analysis to date. The form and content of this report needs to be decided.
- We need to understand TMC's rent and/or capital investment threshold for the new facility.
- We need to more fully understand if the Fire District's timing is on a parallel track with this effort.
- We need to get a handle on the land parcel acquisition costs in order to factor them into the financial analysis.
- We need to discuss and determine a new structure to further the analysis that includes the developer, parcel owners and anchor tenants.

Summary

- A market driven/developer financed new facility for TMC is a option
- Expanded services and more integration into the market would strengthen TMC, including ACA implementation, be welcomed by public
- Two market tracks have emerged – retail and healthcare
- The parcel at Society Turn for healthcare and TOT RV and MV for retail are viable

DISCUSSION DRAFT

Introduction

Halsa Advisors has prepared the following document in order to present initial findings across three areas of planning to date:

1. Market Assessment
2. Emerging Interview Themes and Initial Observations
3. Preliminary Program Considerations

Halsa has synthesized previous planning analysis and conclusions to confirm direction, integrate with current planning efforts, and address gaps as appropriate. Reviewed planning documents include, among others:

- Telluride Medical Center (TMC) Strategic Plan, 2013
- Patient Utilization Assessment – Turning Point, 2013
- TMC Feasibility Analysis – Mahlum Architects, 2008
- TMC Program – Stroudwater and Neenan, 2006

This document will continue to evolve over time based on results of regional/national interviews, TMC, and community feedback.

DISCUSSION DRAFT

Market Assessment

The Market Assessment incorporates previously completed studies and new analyses by Halsa Advisors and is meant to provide a foundation for planning. The review is broadly organized into the following elements:

- Service Area
- Isolation Factor
- Demographics
- Seasonality
- Health Reform
- Physician Need
- Diagnostic and Treatment Demand

DISCUSSION DRAFT

Service Area

Turning Point Healthcare Advisors' assessment of patient utilization determined a four-ZIP Code primary service area for Telluride Medical Center. They also analyzed inpatient and outpatient data for the 11 most proximal counties. Key findings from their report include:

- Overall population growth in the primary service area of about 0.64% per annum over the next five years
- Nearly 85% of inpatients residing in the PSA sought care at one of three hospitals: Montrose Memorial Hospital (~50%); St. Mary's in Grand Junction (~23%); or Mercy in Durango (~11%)
- Hospital-based outpatient services were more fragmented that inpatient services in the PSA, with seven hospitals accounting for roughly 85% of the market in 2012

Halsa Advisors updated the demographic study with the latest population estimates from Claritas for the PSA. We observed a notable distinction between the updated population estimates based on Claritas data, and the population estimates conducted previously that were based on a mix of ESRI and Claritas data. The updated population figures suggest that the PSA has about 15.5% fewer residents than indicated in Turning Point's study.

		Claritas		ESRI & Claritas*	
ZIP Code	City	2013	2017	2013	2017
81320	Rico	626	637	587	599
81426	Ophir	387	399	333	341
81430	Placerville	672	695	694	702
81435	Telluride	4,954	5,239	6,528	6,710
Total		6,639	7,055	8,142	8,352

*Turning Point Healthcare Advisors (Jan., 2013)

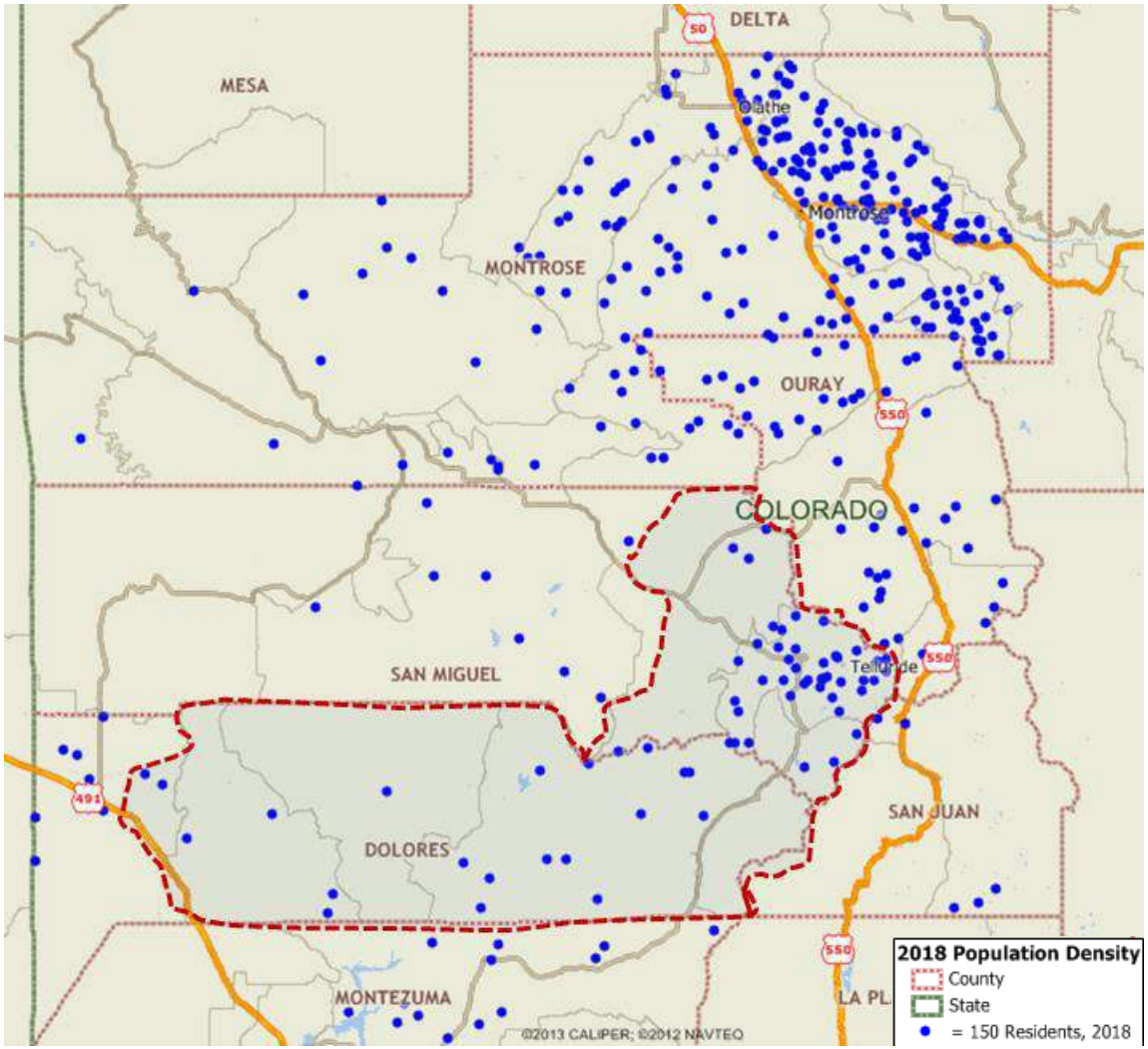
DISCUSSION DRAFT

Service Area

On the map to the right, the red-dashed line indicates the PSA as defined by Turning Point, and the blue dots represent projected 2018 population density in increments of 150 residents.

- Approximately 75% of residents in the PSA are located within Telluride (ZIP Code 81435)
  - As addressed on the next slide, the broad westward extension of PSA ZIP Code 83120 (Rico) may end up overestimating the size of the primary market
- Montrose, the nearest large community, has more than 4 times as many residents as Telluride

2018 Population Density



Sources: Claritas (2013); Turning Point Healthcare Advisors ; Halsa Advisors analysis

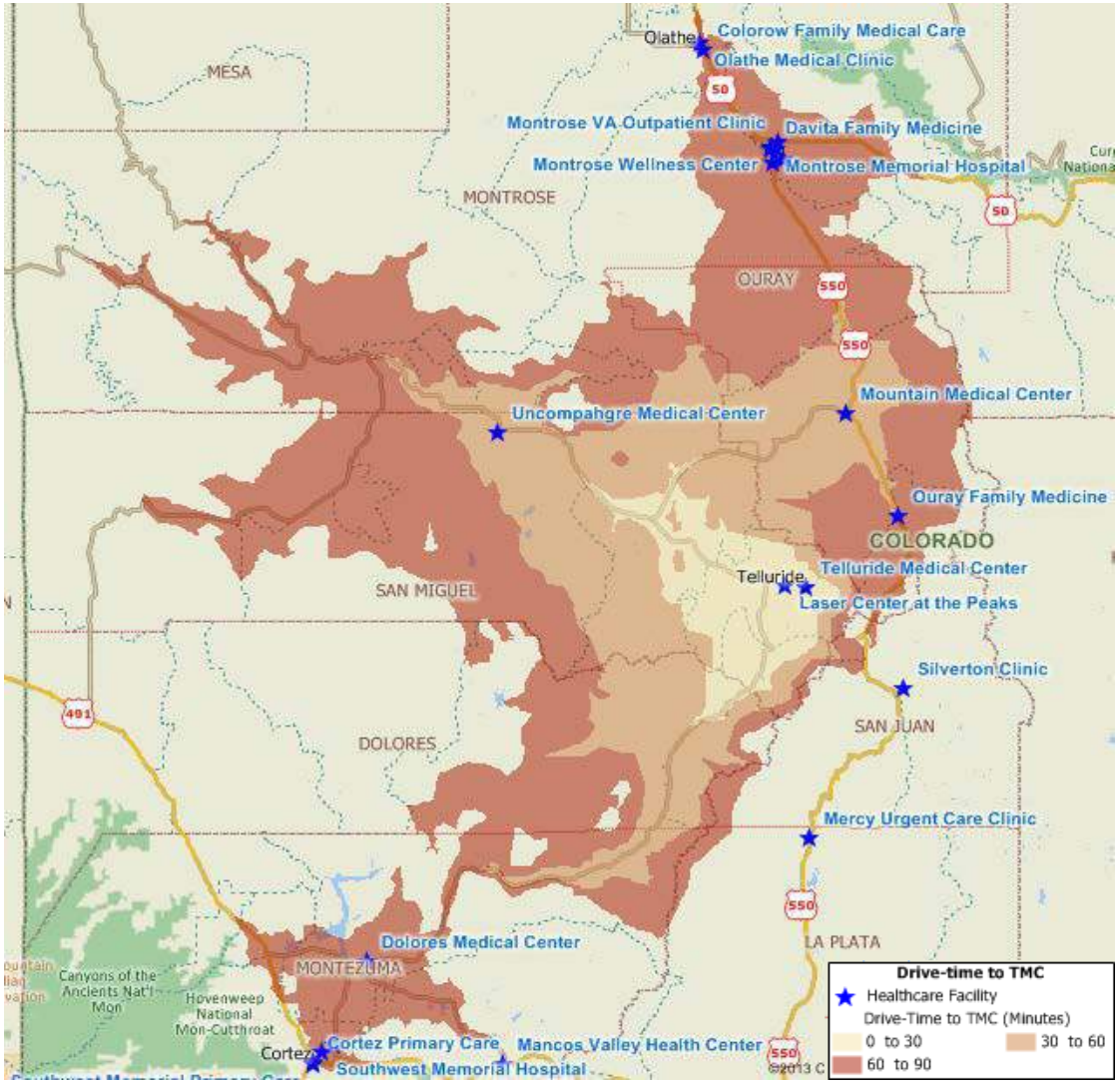
DISCUSSION DRAFT

Isolation Factor

An analysis of 30 minute, 60 minute, and 90 minute drive-time radii around TMC illustrates the isolated nature of the community.

- As noted in the TMC Strategic Plan 2013, the mountainous geography of the area and Telluride's location at the end of a box canyon limit accessibility to Telluride, particularly from the east
- The nearest hospital is 65 miles away
- Telluride is approximately a 90 minute commute from Montrose, and a greater than 90 minute drive from Cortez

Drive-Time to Telluride

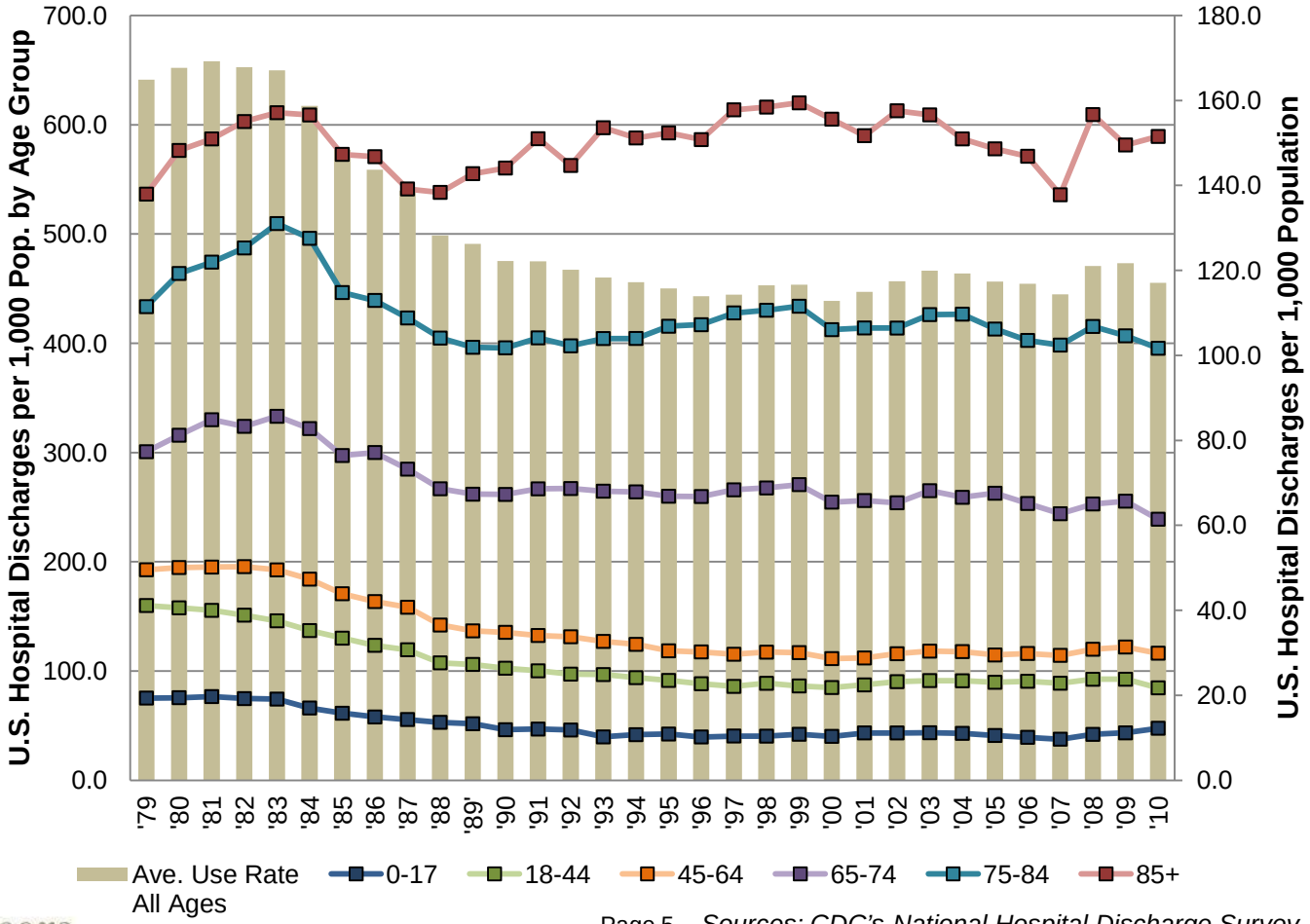


 Sources: Claritas (2013); Halsa Advisors analysis

DISCUSSION DRAFT

Demographic Assessment

Prior studies have downplayed the influence of population aging in Telluride because (1) the community is relatively young, and (2) its residents and visitors tend to be healthier. However, given that elderly residents use health care at multiples of younger age cohorts, we believe it is critical to understand population growth on an age-adjusted level.



Sources: CDC's National Hospital Discharge Survey, 1979 to 2010; Halsa Advisors analysis

DISCUSSION DRAFT

Demographic Assessment – Aging Impact

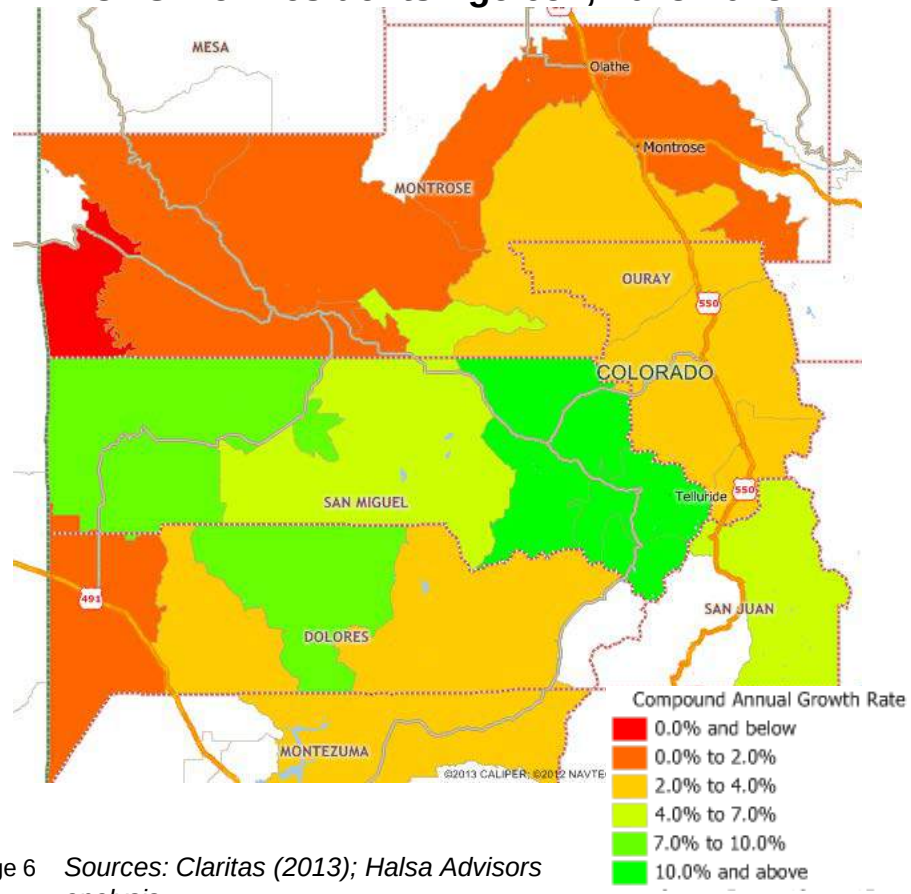
Halsa Advisors updated the demographic profile for the primary service area, as well as for the five most proximal counties. Though Telluride is a young community by national standards, this may be changing slowly, with net population loss projected for the 18 to 44 age group, and close to or more than double digit compound annual growth projected in all senior age groups.

	Primary Service Area			CAGR*	
Age Group	2000	2013	2018	'00-'13	'13 - '18
0-17	907	1,315	1,445	2.9%	1.9%
18-44	3,195	2,605	2,431	-1.6%	-1.4%
45-64	1,421	2,111	2,219	3.1%	1.0%
65-74	127	491	737	11.0%	8.5%
75-84	43	101	195	6.8%	14.1%
85+	15	16	28	0.5%	11.8%
Total	**5,708**	**6,639**	**7,055**	**1.2%**	**1.2%**

*Compound Annual Growth Rate

	Five-County Service Area			CAGR*	
Age Group	2000	2013	2018	'00-'13	'13 - '18
0-17	11,087	12,619	12,639	1.0%	0.0%
18-44	16,112	16,170	15,955	0.0%	-0.3%
45-64	11,765	16,030	15,074	2.4%	-1.2%
65-74	3,188	5,779	6,801	4.7%	3.3%
75-84	2,049	2,631	2,935	1.9%	2.2%
85+	772	1,206	1,246	3.5%	0.7%
Total	**44,973**	**54,435**	**54,650**	**1.5%**	**0.1%**

CAGR of Residents Age 65+, 2013-2018



Sources: Claritas (2013); Halsa Advisors analysis

DISCUSSION DRAFT

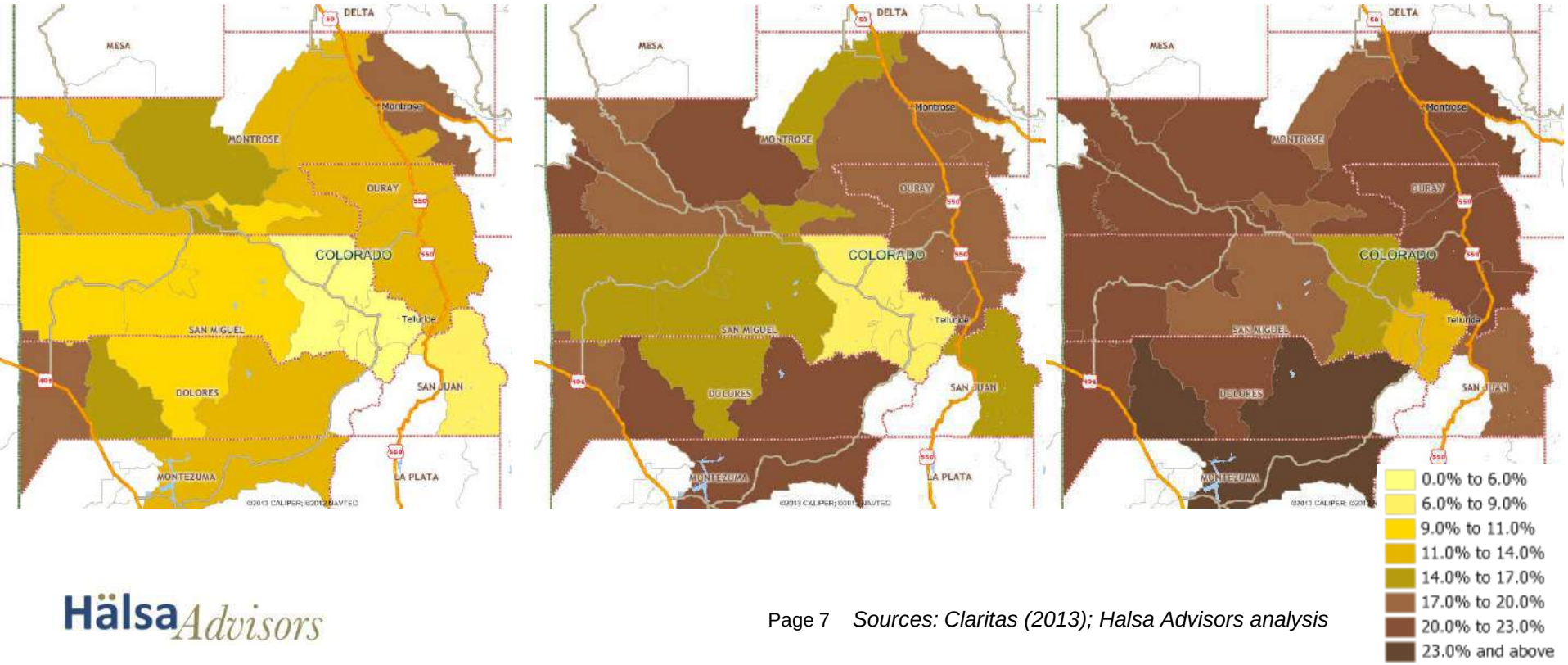
Demographic Assessment – Aging Impact

By 2018, the majority of communities are projected to have seniors account for more than 20 percent of the total population.

- Not only do elderly groups utilize dramatically more inpatient and outpatient services than younger groups, but they are much less willing to travel to receive care

Percent of Population Age 65+

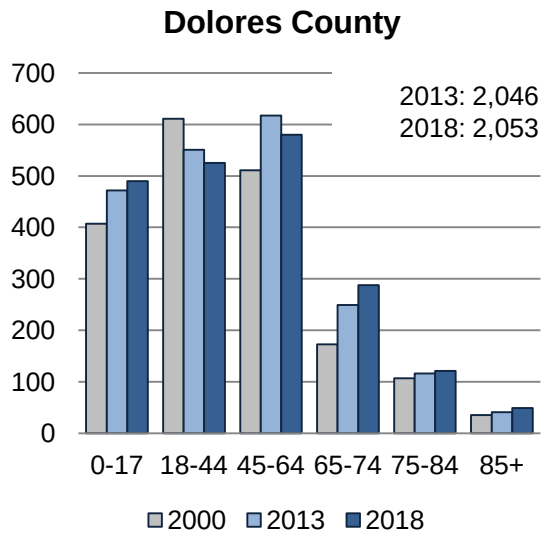
2000 **2013** **2018**

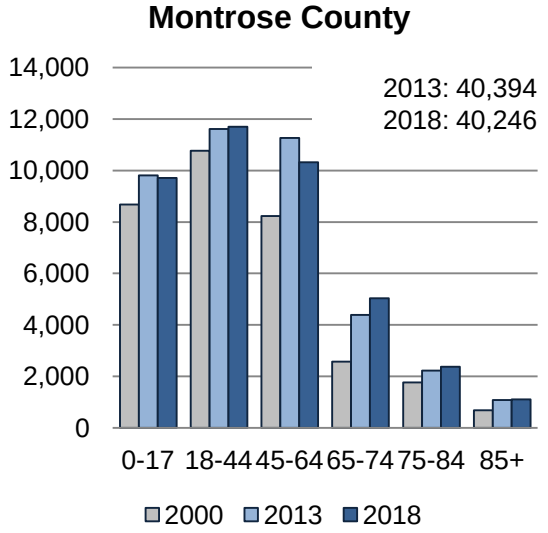


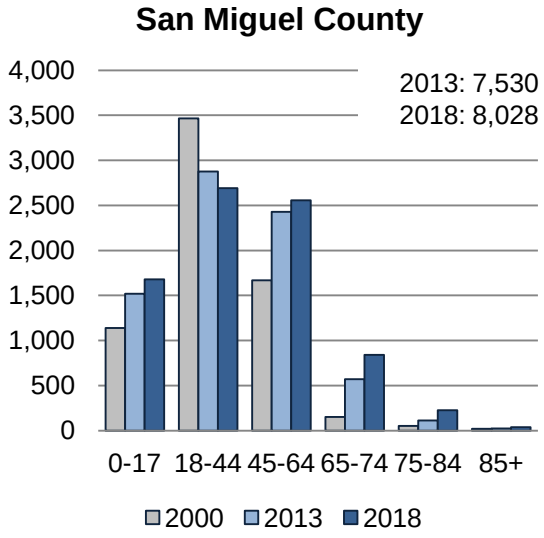
 Sources: Claritas (2013); Halsa Advisors analysis

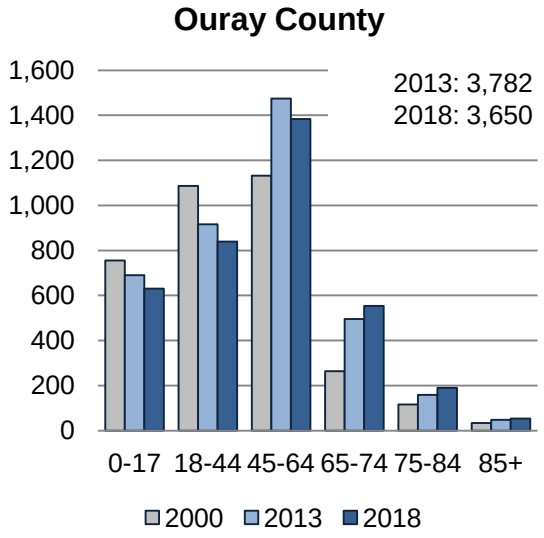
DISCUSSION DRAFT

Demographic Assessment - Summary by County









 Sources: Claritas (2013); Halsa Advisors analysis

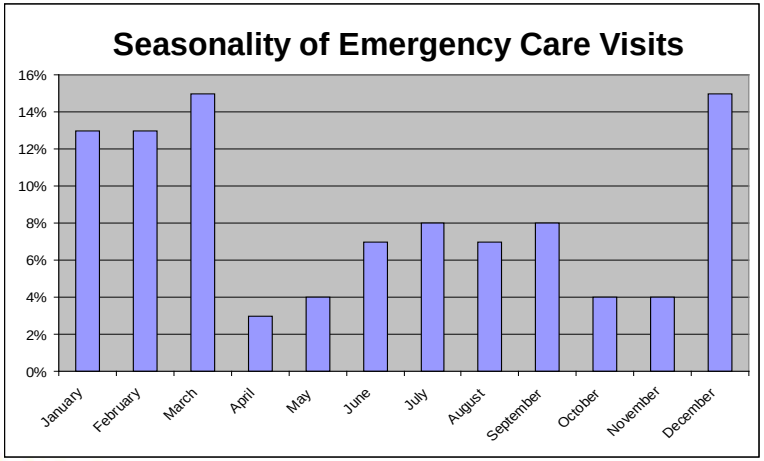
DISCUSSION DRAFT

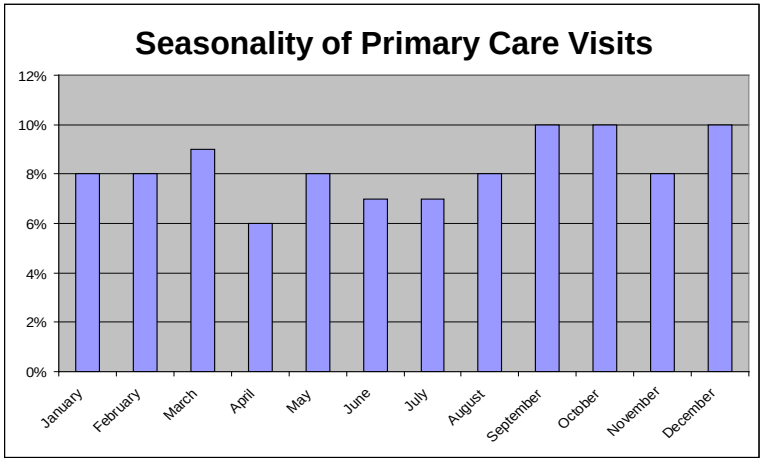
Seasonality Factor

Previous studies have highlighted how seasonal tourism and migration patterns of second homeowners in Telluride affects local demand for health care. It is important to comprehensively investigate this issue and its corollary implications on capacity planning.

According to the TMC Strategic Plan 2013:

- ~20% of TMC's visits are from patients whose primary residence is outside of the service area
- TMC experiences high seasonal fluctuations in patient volumes for emergency care, and to a much lesser extent primary care
- This seasonal business model is driven by tourists and second homeowners during the winter ski season (late November to early April) and summer
- Among the tourist and temporary resident population, the need for health care tends to be skewed to primary care and emergency care. They also tend to have relationships with providers near their primary residences, and often prefer to access non-emergency healthcare elsewhere.





Physician Need

A Health Care Needs Assessment was completed in 2006, which identified six services "needing additional local capacity": pediatric services, orthopedic services, mental health services, birthing, cardiology and ambulatory surgery.

The Stroudwater Report, also completed in 2006, identified family and general practice, internal medicine, obstetrics and gynecology and pediatrics as the highest demand services followed by emergency medicine, anesthesiology, radiology and orthopedics.

The most recent study, conducted in late 2010 by Health Care Futures, confirmed that the local population base was insufficient to support more than a fraction of a full-time physician in most specialties. One of the recommendations was to continue to work closely with regional providers to improve access to specialty coverage both in terms of visiting specialists and through telemedicine.

- Small population base, geographic isolation, and inadequate regional supply of many of the needed specialties have proven to be barriers in attracting a more broad array of regular, visiting specialists

Sources: TMC Strategic Plan 2013; Healthcare Future (2010); Stroudwater Report (2006); Health Care Needs Assessment (2006)

DISCUSSION DRAFT

Physician Need – PSA

Halsa Advisors utilized updated population statistics and a proprietary model to estimate physician need by specialty for the Telluride PSA and Montrose County, based on national, age-adjusted physician-to-population ratios.

- Outputs of our model—presented on the next slide—project physician need at 2018 irrespective of practice location (e.g., hospital, MOB, specialty center)
- Physicians age 63 and above were excluded from the supply estimate in the baseline assessment
- Physician supply estimates were calculated based on publicly available information (e.g., physician registries, hospital websites)

Our findings are largely consistent with prior studies. With respect to the primary service area, the greatest need appears to be primary care physicians, particularly in the fields of internal medicine and pediatrics, and to a lesser extent obstetrics. Other higher need specialties include psychiatry, anesthesiology, cardiology, and orthopedic surgery.

Physician need in Montrose is greatest in specialty medicine, particularly cardiology, gastroenterology, pulmonary disease and critical care. Other higher need specialties include psychiatry, anesthesiology, radiology, and urology.

- Primary care physician demand appears to be fully met in Montrose, with the exception of obstetrics

Specialty	Supply (Phys.)	Baseline Demand Telluride PSA		Surplus (Deficit) Telluride PSA 2018	
PRIMARY	3.0	6.2	4.9	(3.2)	(1.9)
Family Medicine	3.0	2.4	1.9	0.6	1.1
Internal Medicine	0.0	2.2	1.8	(2.2)	(1.8)
Ob/Gyn	0.0	0.7	0.5	(0.7)	(0.5)
Pediatrics	0.0	0.9	0.8	(0.9)	(0.8)
SPECIALTY MEDICINE	0.0	2.3	1.9	(2.3)	(1.9)
Allergy/Immunology	0.0	0.1	0.1	(0.1)	(0.1)
Cardiology	0.0	0.5	0.4	(0.5)	(0.4)
Dermatology	0.0	0.2	0.2	(0.2)	(0.2)
Endocrinology	0.0	0.1	0.1	(0.1)	(0.1)
Gastroenterology	0.0	0.3	0.2	(0.3)	(0.2)
Hematology/Oncology	0.0	0.2	0.2	(0.2)	(0.2)
Infectious Disease	0.0	0.1	0.1	(0.1)	(0.1)
Maternal-Fetal Medicine	0.0	0.0	0.0	(0.0)	(0.0)
Neo-Perinatal Medicine	0.0	0.1	0.1	(0.1)	(0.1)
Nephrology	0.0	0.1	0.1	(0.1)	(0.1)
Neurology	0.0	0.2	0.2	(0.2)	(0.2)
Pulm. Dis. & Critical Care	0.0	0.2	0.2	(0.2)	(0.2)
Rheumatology	0.0	0.1	0.1	(0.1)	(0.1)
SURGERY	1.0	2.2	1.8	(1.2)	(0.8)
Cardiothoracic Surgery	0.0	0.1	0.1	(0.1)	(0.1)
Colon & Rectal Surgery	0.0	0.0	0.0	(0.0)	(0.0)
General Surgery	1.0	0.5	0.4	0.5	0.6
Neurological Surgery	0.0	0.1	0.1	(0.1)	(0.1)
Ophthalmology	0.0	0.4	0.3	(0.4)	(0.3)
Orthopedic Surgery	0.0	0.4	0.4	(0.4)	(0.4)
Otolaryngology	0.0	0.2	0.2	(0.2)	(0.2)
Plastic Surgery	0.0	0.1	0.1	(0.1)	(0.1)
Urology	0.0	0.2	0.2	(0.2)	(0.2)
Vascular Surgery	0.0	0.1	0.0	(0.1)	(0.0)
OTHER	4.0	3.4	2.7	0.6	1.3
Anesthesiology	0.0	0.8	0.7	(0.8)	(0.7)
Emergency Medicine	3.0	0.7	0.5	2.3	2.5
Pathology	0.0	0.3	0.2	(0.3)	(0.2)
Phys Medicine & Rehab	0.0	0.2	0.1	(0.2)	(0.1)
Psychiatry	0.0	0.8	0.6	(0.8)	(0.6)
Radiation Oncology	0.0	0.1	0.1	(0.1)	(0.1)
Radiology	1.0	0.6	0.5	0.4	0.5

Specialty	Supply (Phys.)	Baseline Demand Montrose		Surplus (Deficit) Montrose 2018	
PRIMARY	36.0	35.9	28.5	0.1	7.5
Family Medicine	14.0	13.4	10.6	0.6	3.4
Internal Medicine	13.0	12.6	10.1	0.4	2.9
Ob/Gyn	2.0	3.6	2.8	(1.6)	(0.8)
Pediatrics	7.0	6.3	5.0	0.7	2.0
SPECIALTY MEDICINE	5.0	14.3	11.5	(9.3)	(6.5)
Allergy/Immunology	0.0	0.5	0.4	(0.5)	(0.4)
Cardiology	1.0	3.7	2.9	(2.7)	(1.9)
Dermatology	2.0	1.3	1.0	0.7	1.0
Endocrinology	0.0	0.5	0.4	(0.5)	(0.4)
Gastroenterology	0.0	1.5	1.2	(1.5)	(1.2)
Hematology/Oncology	1.0	1.5	1.2	(0.5)	(0.2)
Infectious Disease	0.0	0.6	0.5	(0.6)	(0.5)
Maternal-Fetal Medicine	0.0	0.2	0.2	(0.2)	(0.2)
Neo-Perinatal Medicine	0.0	0.4	0.3	(0.4)	(0.3)
Nephrology	0.0	0.8	0.7	(0.8)	(0.7)
Neurology	1.0	1.4	1.1	(0.4)	(0.1)
Pulm. Dis. & Critical Care	0.0	1.3	1.1	(1.3)	(1.1)
Rheumatology	0.0	0.5	0.4	(0.5)	(0.4)
SURGERY	11.0	12.7	10.2	(1.7)	0.8
Cardiothoracic Surgery	0.0	0.6	0.5	(0.6)	(0.5)
Colon & Rectal Surgery	0.0	0.2	0.2	(0.2)	(0.2)
General Surgery	3.0	3.0	2.4	(0.0)	0.6
Neurological Surgery	0.0	0.6	0.5	(0.6)	(0.5)
Ophthalmology	3.0	2.2	1.8	0.8	1.2
Orthopedic Surgery	4.0	2.5	2.0	1.5	2.0
Otolaryngology	0.5	1.2	0.9	(0.7)	(0.4)
Plastic Surgery	0.5	0.8	0.7	(0.3)	(0.2)
Urology	0.0	1.2	1.0	(1.2)	(1.0)
Vascular Surgery	0.0	0.3	0.3	(0.3)	(0.3)
OTHER	21.0	19.4	15.5	1.6	5.5
Anesthesiology	3.0	4.7	3.8	(1.7)	(0.8)
Emergency Medicine	11.0	3.7	3.0	7.3	8.0
Pathology	1.0	1.6	1.3	(0.6)	(0.3)
Phys Medicine & Rehab	1.0	1.0	0.8	0.0	0.2
Psychiatry	2.0	4.5	3.6	(2.5)	(1.6)
Radiation Oncology	1.0	0.5	0.4	0.5	0.6
Radiology	2.0	3.3	2.7	(1.3)	(0.7)

DISCUSSION DRAFT

Diagnostic and Treatment Demand - Ambulatory Surgery

The 2006 Stroudwater Report recommended TMC offer ambulatory surgery services. However, the Telluride Hospital District board decided not to pursue these recommendations, largely on account of insufficient projected volumes to keep surgeons and medical staff proficient; inadequate economic prospects; recruiting and staffing challenges; and patient safety concerns—the nearest hospital is more than 65 miles away.

The TMC Strategic Plan 2013 document detailed that a number of Telluride residents seek surgical treatment outside of the service area. However, it was found that even if surgery were provided locally, many residents would still seek care outside of the service area because they already have trusting relationships with a specialist in another community.

Halsa Advisors used a proprietary approach to forecast ambulatory surgery demand by specialty in a given market, based on national, age-adjusted surgery rates, population demographics, OR throughput, and competitor dynamics.

Our findings suggest that there is insufficient surgical volume generated from the PSA to drive a sustainable program in this area.

	Telluride PSA Surgery Demand		Telluride PSA OR Need	
D&T Modality	2013	2018	2013	2018
Surgery	**1,186**	**1,353**	**0.93**	**1.06**
Cardio/Vascular	30	36	0.02	0.03
ENT	83	90	0.07	0.07
Neurosurgery	73	83	0.07	0.08
OB/GYN	67	70	0.05	0.05
Ophthalmology	132	180	0.07	0.09
Orthopedics	194	211	0.14	0.15
Urology	38	45	0.02	0.03
General / All Other	568	640	0.49	0.56

Sources: TMC Strategic Plan 2013; Stroudwater Report (2006); Halsa Advisors Analysis

Diagnostic and Treatment Demand - Other

We employed a similar approach to forecast ambulatory volumes for several common diagnostic and treatment modalities. The assessment suggests that the provision of most D&T modalities in Telluride would be underutilized assets, though they may be an essential complement to expanded specialty care (e.g., TMC's visiting specialists program), or simply a convenient offering for local residents and visitors.

- Given the above-average use of emergency services in the Telluride area, and considering significant seasonality factors, the need for D&T modalities may be understated in our study, particularly in those most associated with trauma care, such as general radiography, CT, ultrasound, and to a lesser extent MRI.

	Telluride PSA D&T Procedure Demand		Telluride PSA D&T Unit Need	
D&T Modality	2013	2018	2013	2018
CT	**620**	**690**	**0.14**	**0.15**
MRI	**410**	**450**	**0.21**	**0.23**
Mammo	**1,080**	**1,200**	**0.24**	**0.27**
General Radiography	**2,830**	**3,230**	**0.63**	**0.72**
Ultrasound	**960**	**1,010**	**0.32**	**0.34**
Cardiac Echo	**330**	**400**	**0.17**	**0.20**
GI/Endo	**200**	**240**	**0.17**	**0.20**
Chemotherapy	**290**	**360**	**0.77**	**0.96**

Emerging Interview Themes

We have found good support among providers for the integrated Patient Centered Medical Home (PCMH)concept and the potential to work jointly among other clinical services and the existing TMC

- Mental Health, Pharmacy, Therapy, Nutrition, Wellness

We have found general support for an integrated health and wellness neighborhood concept – something beyond any concept seen elsewhere

- Practitioners at all levels of training and licensure/certification working together to prevent, diagnose, treat, restore

Location is important – most prefer (and some require) a location within Telluride or Mountain Village with accessibility to gondola; Society Turn acceptable for medical services but a less attractive option for other, every-day types of services

The need for a Recreation Center with pool has been identified by multiple interviewees

Two key challenges –

- How do we proceed fairly? How do we choose who's in and who's out?
- What will it cost? How can we afford it?

DISCUSSION DRAFT

Initial Observations - Facilities and Operations

Achieving our required adjacencies will be challenging; achieving our preferred adjacencies will be an even bigger challenge

- ED must be adjacent to imaging
- ED should be adjacent to the primary physicians' clinic
- Primary Care medical home providers should be adjacent to the primary physicians
- Visiting specialty physicians should be adjacent to the primary physicians

Ability to provide adjacent helipad will differ depending on location; highest degree of likely opposition at Telluride or Mt. Village sites

Expansion potential – most likely scenario is a two phase development

- Some services likely to start in phase 2; some phase 1 services may expand as the new facility takes root and succeeds

Alienation factor – How do we choose who is in and who is not?

- Pharmacy
- Chiropractic
- Trainers/fitness providers

DISCUSSION DRAFT

Program Framework

Tier 1 Services Services that exist today and are currently located at TMC; our core Mission services	• Emergency Dept. • Primary Care Clinic • Visiting Specialist Clinic • Radiology • Admin/Support
Tier 2 Services Services that currently exist in the community but that are in separate locations; potential to incorporate more integrally into Medical Home model; good potential for synergies	• Mental Health • Pharmacy • Physical Therapy • Complementary Medicine/Wellness • EMS • Helicopter Landing Zone
Tier 3 Services Services that do not currently exist in the community but that could be supported; impact to both operations and space ***STILL UNDER EVALUATION***	• Overnight Beds? • Infusion? • Endoscopies/Minor Procedures? • Other? ***STILL UNDER EVALUATION***
Tier 4 Services Services that currently exist in the community but that are in separate locations; potential to include within “Health/Wellness Neighborhood” but limited synergies with other clinical services	• Dental Services • Orthodontics • Fitness Center
Tier 5 Services Services that do not currently exist in the community but that could serve as a destination center of excellence; likely to require independent business plan and outside investors along with significant will to “pull” customers to Telluride	• High Altitude Training (ex. HYPO2) • Destination Wellness Center (ex. Andrew Weil Integrative Wellness Program at Miraval Resort and Spa, Tucson, Ariz., The Ranch at Live Oak, Malibu, CA, Esalan, Rancho La Puerta)

	Program Area	Program DGSF	Program Basis	Potential Tenant	Contact
Tier 1 Programs	**Telluride Medical Center**				
	Emergency Department	4,200	7 exam/treatment rooms		
	Imaging	1,800	Includes Rad, CT, U/S, EKG		
	Primary Care	5,400	peak 4 providers in clinic; 9 exam; incl. PFT, Stress		
	Altitude Medicine		Incl. in other spaces – PFT, Stress		
	Administration	1,400			
	Staff Quarters	1,400			
	Facility Support	2,200			
Tier 3 Programs	Visiting Specialist Clinic	1,000	2 exam rooms; leased to independent visiting specialists		
	Observation Beds	800	Two for Critical Access designation		
	Procedure Room	500			
	Mobile MRI		Provide access for mobile MRI		
	Helicopter Landing Zone		Site impact; proximate to ED		
	TMC Subtotal	18,700		Telluride Medical Center	Gordon Reichart
	Visiting Specialist Clinic	2,000	2 providers in clinic; 4 exam rooms	Montrose Medical Center	Mary Snyder, COO
Tier 2 Programs	**Mental Health Offices**	500		Midwest Mental Health	Jon Gordon
	Home Health	2,000		Sinfonia Health, other potential	Fletcher McCusker
	Pharmacy* **	1,800		Sunshine Pharmacy	Mark Watenpaugh
	Physical Therapy* **	2,500		Peak Performance, other potential	Mark Campbell
	Chiropractic	1,000		Adams Chiropractic Clinic, other potential	John Belka, DC
Tier 4 Program	**Fitness*** **	2,000		8750 ALT, other potential	Dennis Lankes
	Dentist	1,800		Telluride Dental	Dr. Grady, DDS
	Crossfit	5,000		Telluride Gymnastics & CrossFit	
	TOTAL	**37,300**			
Tier 5 Program	**Other Potential Programs**		Require further development		
	EMS/Ambulance Garage	20,000	Plug number per Davis Fansler and Paul Major	Telluride Fire Department	John Bennett
	High Altitude Training	TBD	Likely use of TMC diagnostics and partnering with other entities for accommodations and training facilities		
	Baylor	TBD	Potential collaboration in Ortho, Altitude Med, and Telemed		

*** Denotes programs most sensitive to location; will likely not participate if located at Society Turn

	Program Area	Program DGSF	Program/Adjacency Requirements	1st Floor	2nd Floor	Other Floor
Tier 1 Programs	**Telluride Medical Center**					
	Emergency Department	4,200	**Requires 1st floor with good walk-in and ambulance access**	4,200		
	Imaging	1,800	**Requires adjacency to ED**	1,800		
	Primary Care	5,400	Optimal location adjacent to ED but potential to place on 2nd level		5,400	
	Altitude Medicine		Located in Primary Care space			
	Administration	1,400	Flexibility with location			1,400
	Staff Quarters	1,400	Flexibility with location			1,400
	Facility Support	2,200	Flexibility with location			2,200
Tier 3 Programs	Visiting Specialist Clinic	1,000	**Requires adjacent location to Primary Care; no separate entrance**		1,000	
	Observation Beds	800	**Requires adjacency to ED**	800		
	Procedure Room	300	**Requires adjacency to ED**	300		
	Mobile MRI		Provide access for mobile MRI; external footprint to add fixed in future			
	Helicopter Landing Zone		**Proximate to ED; horizonatal is preferred but vertical is possible**			
	TMC Subtotal	18,500				
	Visiting Specialist Clinic	2,000	**Optimal location adjacent to Primary Care; no separate entrance**		2,000	
Tier 2 Programs	**Mental Health Offices**	500	**Requires immediate adjacency with Primary Care**		500	
	Home Health	2,000	Flexibility with location			2,000
	Pharmacy	1,800	Location by ED and/or Primary Care with good access to customers	1,800		
	Physical Therapy	2,500	Optimal location on 1st floor but potential for higher floor; good access			2,500
	Chiropractic	1,000	Flexibility with location			1,000
Tier 4 Program	**Fitness**	2,000	Optimal location on 1st floor but potential for higher floor; good access			2,000
	Dentist	1,800	Flexibility with location			1,800
	TOTAL	**32,100**		**8,900**	**8,900**	**14,300**
Tier 5 Program	**Other Potential Programs**		Require further development			
	High Altitude Training	TBD	TBD			
	Baylor	TBD	TBD			

Note: Bolded comments represent required adjacencies

	Program Area	Program DGSF	Program/Adjacency Requirements	1st Floor	2nd Floor	Other Floor
Tier 1 Programs	**Telluride Medical Center**					
	Emergency Department	4,200	**Requires 1st floor with good walk-in and ambulance access**	4,200		
	Imaging	1,800	**Requires adjacency to ED**	1,800		
	Primary Care	5,400	Optimal location adjacent to ED but potential to place on 2nd level	5,400		
	Altitude Medicine		Located in Primary Care space			
	Administration	1,400	Flexibility with location			1,400
	Staff Quarters	1,400	Flexibility with location			1,400
	Facility Support	2,200	Flexibility with location			2,200
Tier 3 Programs	Visiting Specialist Clinic	1,000	**Requires adjacent location to Primary Care; no separate entrance**	1,000		
	Observation Beds	800	**Requires adjacency to ED**	800		
	Procedure Room	300	**Requires adjacency to ED**	300		
	Mobile MRI		Provide access for mobile MRI; external footprint to add fixed in future			
	Helicopter Landing Zone		**Proximate to ED; horizonatal is preferred but vertical is possible**			
	TMC Subtotal	18,500				
	Visiting Specialist Clinic	2,000	**Optimal location adjacent to Primary Care; no separate entrance**	2,000		
Tier 2 Programs	**Mental Health Offices**	500	**Requires immediate adjacency with Primary Care**	500		
	Home Health	2,000	Flexibility with location			2,000
	Chiropractic	1,000	Flexibility with location			1,000
	Wellness	3,000	Optimal location on 1st floor but potential for higher floor; good access			3,000
	EMS/Ambulance Garage	20,000	Accommodates administrative and residence functions along with 2 ambulances and a ladder truck; 5,000 sf is medical office space and 15,000 is garage space that may be near but not necessarily fully integrated with remaining building	15,000		5,000
Tier 3 Program	**Dentist**	1,800	Flexibility with location			1,800
	Crossfit	5,000	Requires minimum 18' ceiling height			5,000
	TOTAL	**53,800**		**31,000**		**22,800**
Tier 5 Program	**Other Potential Programs**		Require further development			
	High Altitude Training	TBD	TBD			
	Baylor	TBD	TBD			

Note: Bolded comments represent required adjacencies

Piorities - Retail

	Program Area	Program DGSF	Priority High	Medium	Low	Comment
Tier 1 Programs	**Telluride Medical Center**					
	Emergency Department	4,200	4,200			
	Imaging	1,800	1,800			
	Primary Care	5,400	5,400			
	Altitude Medicine					
	Administration	1,400	1,400			
	Staff Quarters	1,400	1,400			
	Facility Support	2,200	2,200			
Tier 3 Programs	Visiting Specialist Clinic	1,000	1,000			
	Observation Beds	800	800			
	Procedure Room	300	300			
	Mobile MRI					
	Helicopter Landing Zone					
	TMC Subtotal	18,500	18,500	0	0	TMC is the core of the development
	Visiting Specialist Clinic	2,000	2,000			CEO and COO at Montrose indicated a serious interest in establishing a visiting specialist clinic that they could rotate their employed specialists through. This would represent a marked programmatic improvement for the community.
Tier 2 Programs	**Mental Health Offices**	500	500			Director from Midwest Mental Health indicated serious interest in planning 2-3 offices in close proximity to the primary care clinic to support a patient centered medical home concept. Like TMC, this group is challenged from a funding standpoint.
	Home Health	2,000		2,000		Owner, Fletcher McCusker, is interested in bringing one of his Home Health franchises to Telluride. Their would be some potential for programmatic synergies but primarily this space is administrative and could be anywhere.
	Chiropractic	1,000			1,000	Dr. Belka expressed some interest in participating within a health and wellness development. There will only be limited programmatic synergies. Decision will be driven heavily by lease rate.
	Physical Therapy	2,500		2,500		Director of Peak Performance indicated an interest in participating. There would be some moderate potential for programmatic synergies, however, his decision will largely be drive by lease rate.
Tier 4 Programs	**Dentist**	1,800			1,800	There will be little programmatic synergy and decision will be driven entirely by lease rate.
	TOTAL	**28,300**	**21,000**	**4,500**	**2,800**	
Tier 5 Program	**Other Potential Programs**					
	High Altitude Training	TBD				
	Baylor	TBD				

Piorities - Health Care

	Program Area	Program DGSF	Priority High	Medium	Low	Comment
Tier 1 Programs	**Telluride Medical Center**					
	Emergency Department	4,200	4,200			
	Imaging	1,800	1,800			
	Primary Care	5,400	5,400			
	Altitude Medicine					
	Administration	1,400	1,400			
	Staff Quarters	1,400	1,400			
	Facility Support	2,200	2,200			
Tier 3 Programs	Visiting Specialist Clinic	1,000	1,000			
	Observation Beds	800	800			
	Procedure Room	300	300			
	Mobile MRI					
	Helicopter Landing Zone					
	TMC Subtotal	18,500	18,500	0	0	TMC is the core of the development
	Visiting Specialist Clinic	2,000	2,000			CEO and COO at Montrose indicated a serious interest in establishing a visiting specialist clinic that they could rotate their employed specialists through. This would represent a marked programmatic improvement for the community.
Tier 2 Programs	**Mental Health Offices**	500	500			Director from Midwest Mental Health indicated serious interest in planning 2-3 offices in close proximity to the primary care clinic to support a patient centered medical home concept. Like TMC, this group is challenged from a funding standpoint.
	Home Health	2,000		2,000		Owner, Fletcher McCusker, is interested in bringing one of his Home Health franchises to Telluride. Their would be some potential for programmatic synergies but primarily this space is administrative and could be anywhere.
	Wellness	6,000		6,000		Contact of Paul Majors has indicated an interest in Wellness Center space if located at Society Turn
	EMS/Ambulance Garage	20,000		20,000		Potential interest by TFPD pending outcome of Master Plan study.
Tier 4 Program	**Dentist**	1,800			1,800	There will be little programmatic synergy and decision will be driven entirely by lease rate.
	Crossfit	5,000				Owner has indicated interest in participating. There will only be limited programmatic synergies. Decision will be driven heavily by lease rate.
	TOTAL	**55,800**	**21,000**	**28,000**	**1,800**	
Tier 5 Program	**Other Potential Programs**					
	High Altitude Training	TBD				
	Baylor	TBD				

Telluride Medical and Specialty Center

Creating a Vision for the Future of Health and Wellness in the Greater Telluride Region

DRAFT – Initial Site Assessment/Threshold Analysis

PREPARED FOR:

TELLURIDE FOUNDATION

PRESENTED BY:

FRAUENSHUH INC.
&
SPERIDES REINERS ARCHITECTS

FRAUENSHUH
Commercial Real Estate Group

June 4, 2013

FRAUENSHUH
Commercial Real Estate Group

June 4, 2013

Via email delivery to: paul@telluridefoundation.org

Paul Major
Telluride Foundation
220 East Colorado Avenue, Suite 106
P.O. Box 4222
Telluride, CO 81435

Re: Initial Site Assessment and Threshold Analysis

Dear Mr. Major,

It is our pleasure to deliver to you the enclosed Site Assessment/Threshold Analysis of four potential sites for an integrated health, wellness and medical center facility development to serve the greater Telluride and Mountain Village area.

The four sites that were studied are as follows:

SITE A - Town of Telluride Site
SITE B - Society Drive Site
SITE C - Mountain Village 1007-1008 Site
SITE D - Mountain Village Town Hall Site

The enclosed assessment is intended to serve as information and guidance in determine further evaluation of one or more of the identified sites as a potential location for this project.

We look forward to continuing to support the evaluation and feasibility study of this project with the Telluride Foundation and its project team.

Sincerely,

David M. Anderson
Senior Vice President

Elliot D. Zismer
Associate

Eric A. Reiners
Principal, SRa

Enclosure

Executive Summary

Introduction

Frauenshuh has been engaged by the Telluride Foundation (Foundation) to conduct an initial assessment of the potential health care facility development capacity, suitability and preliminary feasibility issues associated with four sites in the area serving the communities of Telluride and Mountain Village. The assessment is intended to serve as information and guidance in determine further evaluation of one or more of the identified sites as a potential location for local healthcare facility development that would include the Telluride Medical Center (TMC) and specialty care providers as an integrated health and wellness center for the greater area.

The communities of Telluride and Mountain Village possess unique physical, historic and local economic attributes that challenge many conventional considerations involved in the design and delivery of local and regional healthcare services. It is a reality, however, that the local region must maintain and develop new and expanded healthcare resources including practitioners, as well as equipment, technologies and facilities that ensure the timely and effective delivery of health care services both for primary and ambulatory specialty care. It is evident that the most vibrant and attractive communities are those that possess superior healthcare services as a driving force or strong complement to the strength of their greater community assets.

About the Sites

A total of four (4) sites were evaluated during the scope of this assessment. Two of the sites reside in Mountain Village, one in Telluride and one in the County of San Miguel. The four sites were identified for their generally known capacity to accommodate commercial development and specifically as having potential as suitable sites for local medical and healthcare related service delivery. Each of the sites possesses unique characteristics that are considered strengths as well as weaknesses as an area health care facility destination. It is important to note that the assessment does not weigh factors associated with community preference or geo-political reasons or rationale for one site versus another. These considerations will be further weighed in studies to be conducted by consultants retained by the Telluride Foundation that will further define and assess such issues.

Site Evaluation Criteria

The assessment set out to apply a score to a set of seven (7) evaluation criteria that focus on key factors that are relevant to the consideration of a site as a health and wellness center location. These criteria are further described and defined as follows:

-Infrastructure/ Access to Utilities & Parking
- Site Access/ EMS/ Helipad
-Parcel Availability/ Encumbrances
-Approval Procedures/ Timeframe
-Future Expansion Possibilities
-Adjacencies (Programmatic)
-Sustainable Opportunities

A score ranging from 1-5 (one being lowest and five being highest) was applied to each of the criteria for each site and a total score ranking was reached as a basis of measurement and comparison of the sites.

Economic Considerations

It is important to also note here that economic variables, while evaluated and further discussed in this assessment, were not used as a measurement in the site evaluation comparison. There are several reasons for this. First, there have been no formal discussions with any of the property owners relative to the cost to acquire or develop the properties. Second, the design and development constraints for each of the sites are significant on different levels. For example, the Town of Telluride site would appear to require structured parking to adequately serve the facilities. While structured parking is a sizeable investment, various means of financing and delivering this type of infrastructure through creative means such as tax increment financing and local bonding authorities may off-set the economic limitations each site may present.

The economic evaluation of the sites is intended to provide guidance and serve as a basis of discussion about the magnitude of the investment in building and infrastructure that would be involved in the venture. Development economics will become an important component of the evaluation of one or more of the preferred sites that emerge as opportunities for this community asset. For the purpose of this analysis we have ranked the properties according to a "Cost to develop" magnitude of order (Low, Medium, High) evaluation. In addition, financial, capital and health care market realities, including financing terms, investor returns, lease rates, appraisal value and bonded debt obligations will become central to the decisions to be made locally regarding economic and project feasibility.

Site Evaluation Results

The result of the site evaluation process using the eight (8) evaluation criteria is as follows:

Site	Score	Ranking	Average Score	Cost to Develop
Society Drive	25	1	3.57	Low
MV 1007-1008	25	1	3.57	High
MV Town Hall	20	3	2.85	High
Town of Telluride	19	4	2.71	High

A detailed description of the site assessment and scoring is included in the attached package. While each of the sites scored comparatively high on certain criteria, each site scored comparatively low on others. This created an overall ranking that placed each of the sites within just points from the highest to lowest. As such, none of the sites would appear to eliminate themselves on low scoring (sites averaging a score below 2.5 would be strong candidates for elimination). Conversely, none of the sites emerged as a clear "front-runner" in the criteria ranking (sites averaging a score of 4.25 or above would be considered a front-runner caliber site).

Conclusions and Recommendations

The objective of this phase of work was to assess the potential health care facility development capacity, suitability and preliminary feasibility issues associated with four sites in the area serving the communities of Telluride and Mountain Village. Each of the sites possesses unique characteristics that are considered strengths as well as weaknesses as an area health care facility destination. While economic variables were not applied to the scoring of the sites, development economics will become an important component of the evaluation of one or more of the preferred sites that emerge as opportunities for this community asset.

Community preference or geo-political reasons or rationale for one site versus another were not factors considered in this analysis. These considerations will be further weighed in studies to be conducted by consultants retained by the Telluride Foundation that will further define and assess such issues.

Frauenshuh would recommend the following "next-steps":

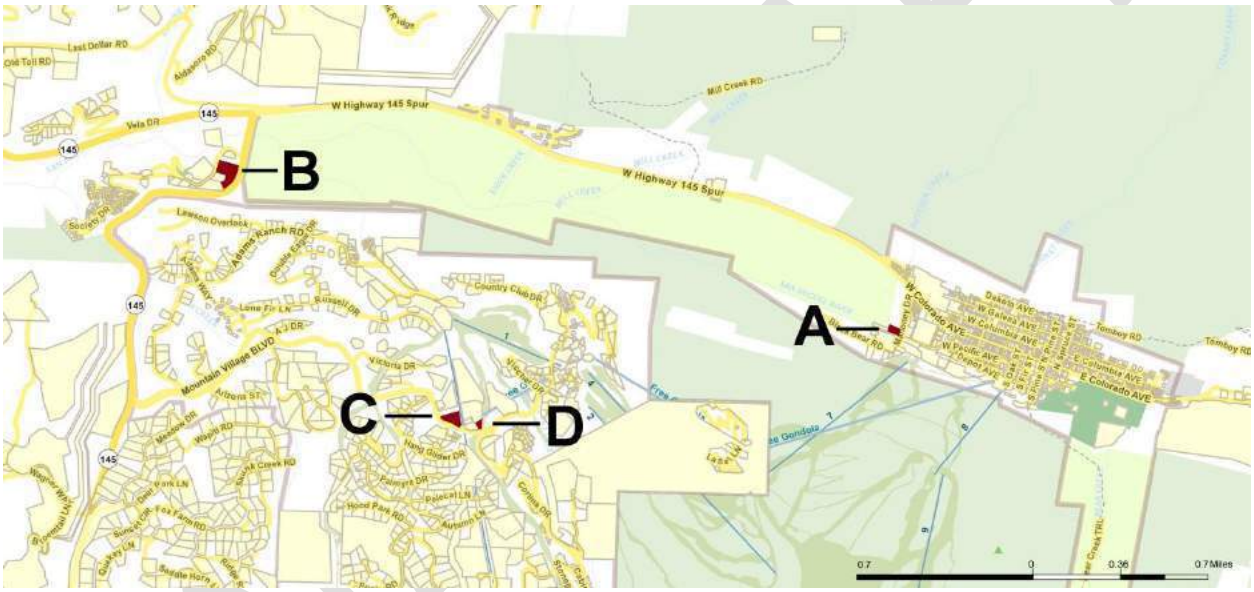
- Authorize marketing consultants to evaluate market potential of the local health care services market, assess demand and determine "threshold" issues for new provider entrants into the Telluride-Mountain Village region.

- Gather community input on alternatives for the "vision" of healthcare and wellness care delivery in the Telluride-Mountain Village region including geo-political considerations regarding location and access to facilities.

- Narrow the evaluation to at least two preferred alternatives for more in depth analysis and feasibility study (based on this report and the findings in outcomes of the activities in the bullet points above). Formalized communications with the property owners of select alternatives and preliminary engineering and design studies would be initiated.

SITE LOCATION MAP

Telluride / Mountain Village



SITE A - Town of Telluride Site

SITE B - Society Drive Site

SITE C - Mountain Village 1007-1008 Site

SITE D - Mountain Village Town Hall Site

PARCEL ASSESSMENT MATRIX CRITERIA

Telluride - Mountain Village Medical Center Site Selection

Score 1 -5 **INFRASTRUCTURE/ACCESS TO UTILITIES & PARKING**

Proximity and availability of required utilities in appropriate size/quantity to adequately serve immediate and future needs. Ability of the site to fulfill basic parking requirements for the facility.

Score 1 -5 **SITE ACCESS/EMS/HELIPAD**

Appropriate access for community members (pedestrian and vehicular), EMS vehicles and helicopter.

Score 1 -5 **PARCEL AVAILABILITY/ENCUMBRANCES**

Opportunity to align development parameters to allow for aggressive progress toward design and construction start.

Score 1 -5 **APPROVAL PROCEDURES/TIMEFRAME**

Required municipal stages of approval and associated timeline conducive to an aggressive development schedule.

Score 1 -5 **FUTURE EXPANSION POSSIBILITIES**

Opportunity for subject property to support additional construction or expanded specialties and services following initial program development.

Score 1 -5 **ADJACENCIES (PROGRAMMATIC)**

Can clinical programmatic components be optimally located relative to the site and each other on/within the subject parcel?

Score 1 -5 **SUSTAINABLE OPPORTUNITIES**

Does the parcel possess the opportunity to foster green building principals utilizing specific exposures, green building systems and LEED principals?

Town of Telluride Site

Telluride, CO

LOT DATA:	Parcel ID:	Pearl Lot Parcel B
	Parcel Size:	Approximately 42,380 SF
	Boundaries:	Mahoney Drive to the east
		Pearl Lot Parcel A (Under Conservation) to the north
		Townhouse Development (Private) to the west
		San Miguel River to the south

LOT NARRATIVE SUMMARY:

The RV Lot has unfettered access to required building and site utilities, some of which already enter or traverse the site. The parcel scored the highest of all those considered in this category. The RV Lot also offers easy pedestrian access, vehicular access and EMS access in addition to the opportunity to offer direct helicopter transport to and from the site. However, the basic timeline for municipal approvals and requisite stages of preliminary development extend well into 2014. This in turn presses the schedule for building design and construction through a period that would into the fourth quarter of 2015, or even the first half of 2016.

Unfortunately, the basic parcel size together with the components that comprise its immediate surroundings – river, roadway, housing development, and wetland – will not support or offer any future expansion beyond the initial construction. Additionally, the site must continue to act as a thoroughfare for the affordable housing development recently completed directly to the west of the site. No other access is available to this development other than through the RV Lot. These factors combine to create the lowest score of all potential sites when considering the possibility of providing expansion opportunity and additional specialties or medical services in the future. The site is also severely limited in its capacity to provide basic parking requirements for the facility. Any reasonable amount of parking provided on site will have to be supplied by the existing parking lot to the South.

Municipal government support for locating the medical center in Telluride is very high, despite the tight programmatic fit on the RV Lot and compressive dimensional limitations that could ultimately affect the efficiency and efficacy of the building program components, the limited opportunity to harness solar exposure and sustainable building strategies, or ever expand the program and building in this location.

The Town of Telluride site places considerable restriction on expansion options for the site. The small footprint will force a vertical structure resulting in a premium on building shell construction. It is estimated that building cost per square foot will increase by 20%.

TOWN OF TELLURIDE SITE SCORING MATRIX

INFRASTRUCTURE	ACCESS	ENCUMBRANCES	APPROVALS	EXPANSION	ADJACENCIES	GREEN BUILDING	COST
3	4	4	2	1	2	3	HIGH

TOWN OF TELLURIDE TOTAL SITE SCORE

19

TOWN OF TELLURIDE SITE

Telluride, CO

DRAWING NOT TO SCALE
BOUNDARY DIMENSIONS APPROXIMATE

Society Drive Site

San Miguel County, CO

LOT DATA:	Parcel ID's:	HUB2B, HUB2C, HUB2E
	Parcel Size:	Approximately 180,772 SF
	Boundaries:	Highway 145 to the east and south
		Society Drive to the west
		Commercial property and Gas station (Private) to the north

LOT NARRATIVE SUMMARY:

Society Drive Lot has access to required utility infrastructure; however, this access is encumbered by a utility access agreement with the town of Telluride that must be modified in conjunction with the Lawson Hill Property Owners in order to complete the development. It is understood that this agreement will be achievable if the Society Dr. site is chosen based on the other factors described in this analysis. Additionally, although vehicular, EMS and helicopter access to this site are all good given its central valley location half way between Mountain Village and Telluride, direct pedestrian access is the least ideal of all sites considered.

The basic timeline for municipal approvals and requisite stages of preliminary development also lowered the viability of this site. A schedule that includes reconfiguring the boundaries of the included parcels to accommodate the county's requirement for 175 parking spaces, amending the Mater Plan governing the site, re-zoning, completing a traffic study, completing the P.U.D. process, amending the utility agreement, and getting an approved building design proposal could easily extend well into 2014. This again extends the schedule for building design and construction through a period that would stretch into the fourth quarter of 2015, or potentially the first half of 2016.

The basic parcel size and configuration is one of the best of the sites evaluated. Its total area, relatively flat terrain and available options for site access points and site circulation will support a variety of opportunities for future expansion beyond the initial construction. The site also benefits from high visibility and flexibility afforded by its boundary dimensions. These factors combine to create one of the

highest scores of all potential sites when considering the possibility of providing expansion opportunity and additional specialties or medical services in the future. The site also offers the highest potential for harnessing solar exposure and other sustainable building strategies much more effectively than north-facing and physically sheltered sites.

Society Drive provides the most economically favorable conditions in regards to the physical site. Relatively flat topography will require little site work and ample space will allow the facility to expand horizontally. In addition, the site offers enough space to position the required helipad at ground level rather than on the roof of the facility. Pricing for Society Drive is used as the baseline for this analysis because of the conditions described above.

SOCIETY DRIVE SITE SCORING MATRIX

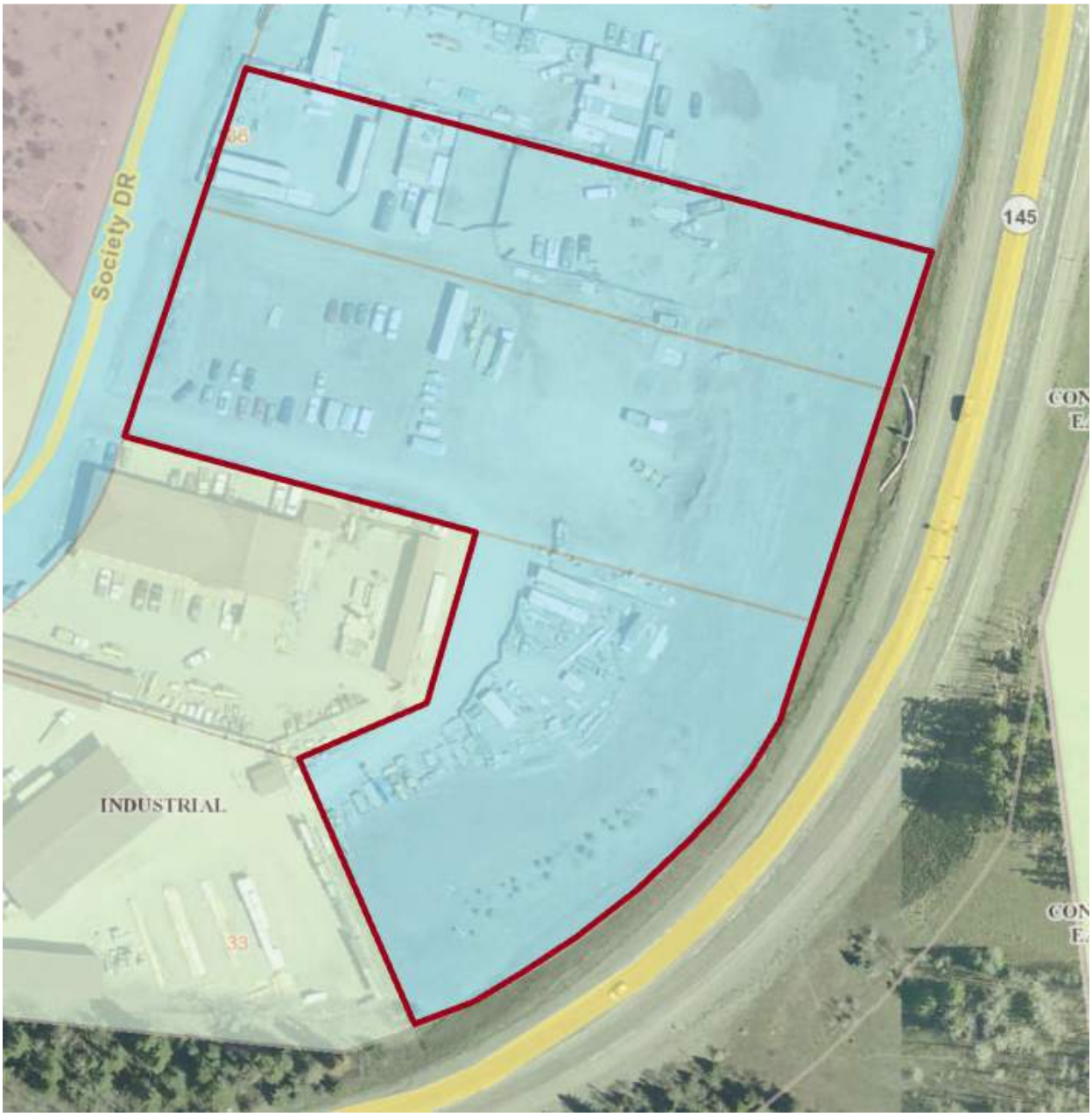
INFRASTRUCTURE	ACCESS	ENCUMBRANCES	APPROVALS	EXPANSION	ADJACENCIES	GREEN BUILDING	COST
3	3	4	2	4	5	4	LOW

SOCIETY DRIVE TOTAL SITE SCORE

25

Society Drive Site

San Miguel, CO



DRAWING NOT TO SCALE
BOUNDARY DIMENSIONS APPROXIMATE

Mountain Village 1007-1008 Site

Mountain Village, CO

LOT DATA:	Parcel ID's:	Lot 1007 – Lot 1008
	Parcel Size:	Approximately 92,600 SF
	Boundaries:	Triangular site:
		Mountain Village Boulevard to the south and west
		Town Hall, Parking Ramp and Grocery to the east
		Village Court Apartments to the north

LOT NARRATIVE SUMMARY:

The Mountain Village 1007-1008 site has access to required utility infrastructure and the site can also readily be configured to accommodate necessary vehicular, EMS and helicopter transport access. Direct pedestrian access to the site is good for Mountain Village residents, and the site also accommodates direct ski-in and ski-out access.

Municipal approvals and requisite stages of preliminary development are the most expeditious of the sites evaluated. The total approval schedule timeline covering required municipal steps through final design review was the shortest in Mountain Village of all sites reviewed as a part of our analysis. Mountain Village has preemptively revised their Comprehensive Plan and initiated the rezoning processes to facilitate the development of a medical facility in Mountain Village. Remaining steps in the approvals process will include vacating and re-aligning of the west-bound lane of Mountain Village Blvd., Design Review Board approval, and final development submittal. The total schedule could be completed in a few months and the site, if selected, could be ready for development early in 2014. This in turn creates a schedule for building design and construction that is far earlier than sites located in Telluride or Society Turn.

The basic parcel size, when combined with vacated land area from Mountain Village Blvd. is one of the best of the sites evaluated, even when setting aside a portion of the site for future use by the school

district. Its total area, together with the configuration of surrounding terrain and available options for site access points and site circulation will support a variety of options for the final building configuration and some additional opportunities for future expansion beyond the initial construction. The site also benefits from some flexibility afforded by its boundary dimensions. These factors combine to create a high score when considering the possibility of providing expansion opportunity and additional specialties or medical services in the future.

Finally, municipal government support for locating a medical center in this location is extremely high in Mountain Village as exhibited by the preemptive steps already in process at the municipal level to help expedite development potential. The town of Telluride and remote surrounding areas that will also provide patronage to the facility may find the mountainside location less desirable, but the parcel holds one of the highest potentials for effectively arranging the internal and external components of the Medical Center program components. Unfortunately, the north-facing slope of the mountainside location and sheltering terrain does not lend high potential for harnessing quality solar exposure and some other sustainable building strategies.

The Mountain Village 1007-1008 site has two primary economic considerations that will increase the baseline assumptions. The location will require the repositioning of Mountain Village Blvd. along with some grading to the existing site. In addition, the size of the lot will force the building to expand vertically and necessitate the required helipad to be placed on the roof. It is estimated that these items will increase the building shell cost by 20%, the site cost by 30%, and add approximately $150,000 for repositioning the road.

MOUNTAIN VILLAGE LOTS 1007-1008 SITE SCORING MATRIX

INFRASTRUCTURE	ACCESS	ENCUMBRANCES	APPROVALS	EXPANSION	ADJACENCIES	GREEN BUILDING	COST
4	3	4	4	4	4	2	HIGH

MOUNTAIN VILLAGE LOTS 1007-1008 TOTAL SITE SCORE

25

Mountain Village 1007-1008 Site

Mountain Village, CO

DRAWING NOT TO SCALE
BOUNDARY DIMENSIONS APPROXIMATE

Mountain Village Town Hall Site

Mountain Village, CO

LOT DATA:	Parcel ID's:	Parcel D, Medical Center Site
	Parcel Size:	Approximately 14,572 SF
	Boundaries:	Town Hall parking lot to the west
		Gondola To the north
		Ski Run to the east
		Mountain Village Blvd. to the south

LOT NARRATIVE SUMMARY:

Mountain Village Town Hall Site has access to required utility infrastructure and the site can also readily be configured to accommodate necessary vehicular, EMS and helicopter transport access (rooftop). Direct pedestrian access to the site is good for Mountain Village residents, and the site also accommodates direct ski-in and ski-out access.

Municipal approvals and requisite stages of preliminary development in Mountain Village are the most expeditious of the sites evaluated. The total approval schedule covering required municipal steps through final design review will be the shortest in Mountain Village of all sites reviewed as a part of our analysis. Mountain Village has preemptively revised their Comprehensive Plan and initiated the rezoning processes to facilitate the development of a medical facility in Mountain Village. Remaining steps in the approvals process will include Design Review Board approval, and final development submittal. The total schedule could be completed in a few months and the site, if selected, could be ready for development early in 2014. This in turn creates a schedule for building design and construction that is far earlier than sites located in Telluride or Society Turn.

The basic parcel size in combination with its topography is constrictive, even when considering that parking will be accommodated in the existing surface lot directly in front of the site, and the parking ramp located behind Town Hall. Its total buildable area, together with the configuration of surrounding

terrain and available options for site access points and site circulation will support limited options for the final building configuration, and will not provide many additional opportunities for future expansion beyond the initial construction. The site also suffers from some inflexibility created by its fixed adjacencies including the Town Hall building, Mountain Village Boulevard, and the ski run to the east. These factors combine to create a low score when considering the possibility of providing expansion opportunity and additional specialties or medical services in the future.

Once again, municipal government support for locating a medical center in this location is extremely high as exhibited by the steps already in process at the municipal level to help expedite development potential and the establishment of a parcel specifically guided and dedicated to medical programs. However, the town of Telluride and remote surrounding areas that will also provide patronage to the facility may find the mountainside location less desirable.

The Medical Building site, due to the limited flat region on the parcel and steep grades that dominate the rest of it, will be slightly restrictive in the efforts to effectively arranging the internal and external components of the Medical Center program components. Unfortunately, the Medical Building Site also suffers from the same short-comings as the Town Hall Center site in Mountain Village given the north-facing slope of the mountainside location and associated terrain – it does not lend itself to the potential for harnessing quality solar exposure, nor does it easily accommodate other sustainable building strategies.

The Mountain Village Town Hall site has two primary economic considerations that will increase the baseline assumptions. The location's topography will require additional site work in order to accommodate the prospective medical center. In addition, the restrictive size of the lot will force the building to expand vertically and necessitate the required helipad to be place on the roof. It is estimated that these items will increase the Building Shell cost by 20% and the Site Work by 30%. While parking capacity may be available nearby (i.e. existing parking structure), the ability to expand parking in optimal proximity to the building is a significant constraint.

MOUNTAIN VILLAGE TOWN HALL SITE SCORING MATRIX

INFRASTRUCTURE	ACCESS	ENCUMBRANCES	APPROVALS	EXPANSION	ADJACENCIES	GREEN BUILDING	COST
3	3	4	4	2	2	2	HIGH

MOUNTAIN VILLAGE TOWN HALL TOTAL SITE SCORE

22

Mountain Village Town Hall Site

Mountain Village, CO

DRAWING NOT TO SCALE
BOUNDARY DIMENSIONS APPROXIMATE

Telluride Health and Wellness
Site Threshold/ Fit Analysis
(by ranking)

Rank	SITE	PHOTO	TOTAL SITE AREA (APPROX)	SITE BUILDING CAPACITY	NUMBER OF FLOORS/ FOOTPRINT/ PARKING	ZONING/LAND USE CONTROLS	SCHEDULE CONSIDERATIONS	ECONOMIC CONSIDERATIONS
1	**Society Turn Lots**		108,770	40,000	2 Floors 20,000 sf footprint 287 Total parking spaces on site (175 dedicated to transit, 112 dedicated to medical center)	Zoning able to accommodate medical facility.	Amendment to master plan, utility agreement and P.U.D process could extend approvals into 2014.	- Est. Hard Costs PSF: $245 - Est. Soft Costs PSF: $45 - Est. Total Costs PSF: $290 * The economic analysis does not make assumptions on extraordinary conditions such as environmental, soils capacity and other zoning constraints that could add additional premium to development costs.

Criteria	Grade
Surrounding Infrastructure/ Access to Utilities	3
Site Access/ EMS/ Helipad	3
Parcel Availability/ Encumbrances	4
Approval Procedures/ Timeframe	2
Future Expansion Possibilities	4
Adjacencies (Programmatic)	5
Sustainable Opportunities	4
TOTAL	**25**

Rank	SITE	PHOTO	TOTAL SITE AREA (APPROX)	SITE BUILDING CAPACITY	NUMBER OF FLOORS/ FOOTPRINT/ PARKING	ZONING/LAND USE CONTROLS	SCHEDULE CONSIDERATIONS	ECONOMIC CONSIDERATIONS
2	**Mountain Village 1007-1008**		92,000	40,000	3 Floors 13,350 sf footprint 75 Parking Spaces On Site Balance Of Spaces Provided In Ramp	Zoning able to accommodate medical facility.	Shortest approval process. Preemptive zone changes to comprehensive plan will reduce approval process to a few months.	- 30% premium on site work - 25% premium on building shell due to vertical expansion and rooftop helipad. - Est. Hard Costs PSF: $302 - Est. Soft Costs PSF: $53 - Est. Total Costs PSF: $355 * The economic analysis does not make assumptions on extraordinary conditions such as environmental, soils capacity and other zoning constraints that could add additional premium to development costs.

Criteria	Grade
Surrounding Infrastructure/ Access to Utilities	4
Site Access/ EMS/ Helipad	3
Parcel Availability/ Encumbrances	4
Approval Procedures/ Timeframe	4
Future Expansion Possibilities	4
Adjacencies (Programmatic)	4
Sustainable Opportunities	2
TOTAL	**25**

Telluride Health and Wellness
Site Threshold/ Fit Analysis
(by ranking)

Rank	SITE	PHOTO	TOTAL SITE AREA (APPROX)	SITE BUILDING CAPACITY	NUMBER OF FLOORS/ FOOTPRINT/ PARKING	ZONING/LAND USE CONTROLS	SCHEDULE CONSIDERATIONS	ECONOMIC CONSIDERATIONS
3	**Mountain Village Town Hall**		14,600	40,000	4 Floors 10,000 sf footprint 12 Parking Spaces Dedicated In Existing Parking Lot Balance of Spaces Provided In Ramp	Zoning able to accommodate medical facility.	Shortest approval process. Preemptive zone changes to comprehensive plan will reduce approval process to a few months.	- 30% premium on site work - 25% premium on building shell due to vertical expansion and rooftop helipad. - Est. Hard Costs PSF: $298 - Est. Soft Costs PSF: $53 - Est. Total Costs PSF: $351 * The economic analysis does not make assumptions on extraordinary conditions such as environmental, soils capacity and other zoning constraints that could add additional premium to development costs.

Criteria	Grade
Surrounding Infrastructure/ Access to Utilities	3
Site Access/ EMS/ Helipad	3
Parcel Availability/ Encumbrances	4
Approval Procedures/ Timeframe	4
Future Expansion Possibilities	2
Adjacencies (Programmatic)	2
Sustainable Opportunities	2
TOTAL	**20**

Rank	SITE	PHOTO	TOTAL SITE AREA (APPROX)	SITE BUILDING CAPACITY	NUMBER OF FLOORS/ FOOTPRINT/ PARKING	ZONING/LAND USE CONTROLS	SCHEDULE CONSIDERATIONS	ECONOMIC CONSIDERATIONS
4	**Town of Telluride Pearl Property**		42,400	40,000	4 Floors 10,000 sf footprint 30 Spaces On-Site	Zoning able to accommodate medical facility.	Approval process will extend into 2014 which could push completion into 2015 or 2016.	- 20% premium on building shell due to vertical expansion. - Est. Hard Costs PSF: $296 - Est. Soft Costs PSF: $54 - Est. Total Costs PSF: $350 * The economic analysis does not make assumptions on extraordinary conditions such as environmental, soils capacity and other zoning constraints that could add additional premium to development costs.

Criteria	Grade
Surrounding Infrastructure/ Access to Utilities	3
Site Access/ EMS/ Helipad	4
Parcel Availability/ Encumbrances	4
Approval Procedures/ Timeframe	2
Future Expansion Possibilities	1
Adjacencies (Programmatic)	2
Sustainable Opportunities	3
TOTAL	**19**

Summary for Internal Use
Telluride Health Ideas Public Engagement Website
Round One Summary

The Telluride Foundation launched a public engagement initiative focused on health and wellness issues, including future programs and/or facilities to support the community's vision for health in the area. Round one of questions launched on Thursday, May 30th and had a soft ending on Wednesday, June 26th. The questions and specific areas of emphasis were developed in collaboration with the Telluride Foundation and stakeholder interviews. Several types of questions were asked including open-ended, idea generation items—such as what is your vision for a healthy Telluride?—to the more concrete—such as selecting the top five healthcare priorities available in Telluride.

The ideas submitted on the site are "crowd sourced." This means other users can add to ideas submitted by their peers and provide an initial assessment on favorability. The online opportunity provide an easy way to include Coloradans who do not ordinarily attend public meetings and those second homeowners who may not be able to attend face-to-face meetings.

Telluride Health Ideas Page Activity

- 2,849 page views
- 303 site visits
- TellurideHealthIdeas has 62 registered site users. Only users who registered were allowed to comment, vote on ideas and participate in polls. Zip code, age and gender are required to become a registered user on the site

In response to several community members having difficulty navigating the site, the Telluride Foundation created an online survey with similar questions. Where appropriate, those data have been incorporated into this report.

IDEAS SUBMITTED BY USERS ON WEBSITE AND ON SURVEY

20 ideas were submitted online by users representing a range of views, perspectives and backgrounds. There were 26 responses on Constant Contact Survey. This section summarizes the ideas raised in both the website and the survey.

QUESTION 1: VISION

The first question on the site asked, what is your vision for a healthy Telluride? (Only asked on TellurideHealthIdeas.org, not on Survey). The following ideas are in order of popularity, or in other words, which ideas crowd sourced to the top. By and large, building a recreation center in Telluride was the most popular idea. There were also several users concerned about the aging population in Telluride and it becoming more and difficult to live in or visit Telluride unless there is access to broader and more specialized medical services.

Theme: Build a Recreation Center

a) Sharon G: *Rec Center for all ages to exercise when the weather is poor.*
The community needs to work together on ideas and not limit our possibilities due to small groups' narrow views. There have been too many good things held back by certain governmental institutions. A rec center would be a positive addition to this community and there is potential to provide additional preventative/wellness services attached to such a center (such as physical therapy, strength training and conditioning, etc.)

b) Blythe S: *An affordable recreation center and a health food store.*
Eating well and exercising are the two biggest ways we can prevent disease and illness. Having a rec center could provide year-round opportunity for exercise. And having a health food store that lasts could be a place where we can make healthy food choices.

c) David C: *Incorporate a rec center with this health care facility.*
The Idarado site east of town probably has numerous clean up issues but would provide a large footprint for a rec center on the scale of those found in Cortez, Gypsum and Boulder.

d) Betsy M: *A recreation center with a 'real' indoor pool - everyone swims!*
A rec center (like Durango, Montrose, etc.) would be ideal. Something with a year round indoor pool, hydrotherapy/hot tub, kid pool (i.e. zero entry like the Salida pool), gym, indoor track, climbing wall etc. Not only would a rec center be great for our locals, it would be a great tourist draw especially in the winter - for those that don't ski.

Theme: New Medical center

a) Mark B: *Think broader than just a new clinic*
Telluride has always out-classed other resorts because of alternative thinking (and lifestyles). That same philosophy should carry over to the medical center. It's my opinion that a clinic should be a destination for those seeking alternative solutions to their health problems with world class visiting medical professionals. The new facility should be the cornerstone of a new tourism base in Telluride for health and wellness; should be large enough to attract the best medical minds either to live and work in Telluride or attend medical conferences that push the bounds of health care. I see a marriage between the clinic, the Peaks and its outdoor healthy programs and spa and what would be the Telluride Health and Medical Institute. And certainly if the new facility can do all of the above, then is surely can continue to meet the basic community needs to take care of the many families that live there.

b) Stuart F: *One stop health care in the area of greatest population density*
A health and wellness center in Telluride. More of the primary population lives in that area as well as a substantial amount of guests year round. It should include physical rehab as well as specialized services so that we don't have to travel to Montrose or Grand Junction. It should cover all age groups from infants to seniors.

c) Dennis M: *Buy tailings pile east of Town Park and put med center there.*
The Town of Telluride should buy the tailings pile east of Telluride. Being a superfund site it should have little assessed value. Plenty of room for a huge medical/health facility, helipad, Festival Grounds for events like Bluegrass (with a large stage facing south for noise control, and perhaps permanent seating similar to the Miller Summerfest Stage in Milwaukee), recreation center, parking, etc.

Other ideas that did not gain much traction or support include:

- Excellent Healthcare with an E.R. that accepts BC/BS
- Proactive preventative care locally
- More specialized practices - especially cardiology

QUESTION 2: LOCAL ECONOMY AND HEALTHCARE

When asked how the health of local residents and access to healthcare services impact the local economy, many users made the correlation that a healthy workforce equals a healthy economy. (This question was asked on both TellurideHealthIdeas.org and the online survey.)

Crowd sourced to the top on website: Stuart F: *Provide high quality care here*
We need to be able to build the confidence level in our region that will cause all primary residents and guests to think of our center before all others. It needs to be readily accessible to the broadest population base and it needs to promote itself as the place to take care of your physical and mental issues.

Theme: Preventative care should be the focus

a) Jules W: *Create a culture of health awareness*
Educate how we can reduce cost with preventative medicine.

b) Betsy M: *Preventative Medicine should be primary goal*
A large med center with alternative options available would be great but it would have to be affordable. But, it should not be exclusionary - all PT's, massage therapists, acupuncturists should get the business even if they don't buy in to the centralized med center. A bigger ER with a helicopter pad would be nice but should be located in the town of Telluride (pearl property?!).

c) Commitment to a healthy lifestyle and adequate prevention services result in lower per capita health-care costs (survey)

d) Easy access translates to more preventive care, more urgent care and less ER visits (survey)

Theme: Lower healthcare premiums (all from online survey)

a) Too many underinsured, specifically retail workers are without insurance involved in adventurous/risky activities. Could better educate employees or employers on availability and costs. These patients cost our local healthcare system a lot of money, as well as the patient who is strapped with a potentially high medical bill from injury.

b) Good overall health of the community could transfer into lower healthcare premiums.

Theme: Expanding care in Telluride (all from online survey)

a) As much basic health care should be provided for within a community. This provides a community with a feeling of security and safety. In addition, it provides economic benefit by keeping money flowing and recirculating within the community.

b) The facility is not in good condition, but TMC works with what they have and do everything possible. The Village and Town are running out of space to build, the new TMC must be large enough to accommodate the growing population's needs.

c) If services could be provided locally less dollars would be spent shopping/eating out/etc. in other communities.

d) Due to our remote access it is important to have basic quality primary and emergency services in order to sustain a vibrant community.

e) The lack of local services necessitates time off work to travel to receive those services and thus result higher expense to replace the worker while they are gone. The combined impact on the employer and the employee deprives the local economy of dollars.

f) Workforce productivity is negatively impacted by a deficiency in healthcare services.

g) I think the more access to healthcare services is available, the more viable our workforce is.

h) Health care services not provided within the community must be sought after outside the community. In some cases, this is appropriate as the economics of scale may not support specialty fields within the community. Public subsidizing of these services may be an undue burden on the citizens, given all the varied needs that have to be provided for with even a small population.

i) If there is good affordable care, locals will use it and stay in better health and keep their health care dollars nearby.

Theme: Aging population leaving

a) Direct impacts include the fact that many of us travel for basic care and it would be better to keep those dollars in the community. Longer term, mountain towns are aging and folks continue to move away for basic care and a better health center could help to retain more residents for longer. An affiliation with a larger hospital in GJ would make this even more compelling.

b) With aging demographics and second home owners, more specialties are needed and there should be health and wellness and longevity programs that attract tourists.

c) I am a 72 year old man who is a part time resident of Mt Village. My wife and I are in Telluride 3-4 months annually. At some point in the foreseeable future, we will either stop coming to Telluride or reduce the amount of time we spend there. This will be because:
    - We are no longer able to ski, hike, etc. because our physical condition has deteriorated;
    - The altitude and severe climate have become hard to handle;
    - Health services that we may require are too far away. That could refer to many things, but most likely it will be the needed for cardiac or cancer care

QUESTION 3: A HEALTHY COMMUNITY

When asked what the best ways to keep the Telluride community healthy, many people responded that they need affordable, healthy food choices. Also a priority for improving the health of the community is a new recreation center and more education on health and wellness and preventative healthcare.

Theme: No improvements needed
Access to great outdoor activities
We already have a great farmer's market
We have a wonderful Telluride Medical Center with outstanding healthcare providers who deliver excellent care.
We really do not have to do anything more

Theme: More food choices
Inexpensive access to fresh fruit & veggies
Access to affordable nutritious foods/organic produce, reasonably priced
Access to healthy foods and healthy prepared foods
Grocery stores could attempt to have better quality produce
Better access to affordable, nutritious food would be another way to keep the community health

Theme: Healthcare Improvements/ Expanding care
Ability to see a specialist locally
Ensure all community members are insured
Improved access to quality, evidence-based, best practice health care would be one way to keep the Telluride community healthy
Holding Primary Care Physicians to high standards and putting them in touch with peers would help them to practice current and best medicine
Providing care management in the community would improve transitions and maintenance of health

Theme: New Recreation Center
Recreational facilities that can be used year round.
More indoor recreational activities such as a recreational center would enhance Telluride for both local residents and visitors
Would love to see a community center to provide affordable access to gym/swimming etc. year round
Add a rec center
Affordable recreational opportunities

Theme: Education and Preventative Care
Greater public education regarding access to health care for low income people who do not qualify for Medicaid
Many people do not know how to have a balanced diet or how to properly exercise
Preventive care and more basic services here so that they are utilized consistently, versus forcing long drives that tend to get deferred.
TMC health seminars for health issues

Annual physical examinations for everyone
Keeping kids healthy starts with elementary school and teaching the fundamentals of diet and exercise.
Need LIFESTYLE/DIET counseling. I feel diet (and exercise) are critical to being healthy and are not sufficiently a part of preventative medicine. It should be a part of every consult.

Theme: Miscellaneous
More hand sanitizer stations offered around town
Business supported rec activities for the employees. Incentives for biking to work, losing weight, reducing alcohol consumption, etc.
Changing the party culture of the town, encouraging more athletic events and reducing the number and volume of the party related festivals. Let's cut back on all of the alcohol inspired concerts and reduce the number of tickets for sale

QUESTION 4: IMPROVING HEALTH IN TELLURIDE

When asked what the best ways to improve health, healthcare and wellness in the Telluride community, many responded with ways to improve collaboration between other healthcare facilities and professionals, ideas for expanding care in Telluride and thoughts on improving wellness and education on health living. This question was asked on the TellurdieHealthIdeas site and the online survey.

Theme: Collaboration with other hospitals and healthcare professionals

a) Stuart F: *Speakers on a variety of topics related to health services*
It should focus on not just getting over an illness or accident but also to educate on how to avoid illness and accidents. Preventive tips.
b) Virginia L: *Bring in specialists more frequently and provide a location for them to see patients*
c) I would like to see collaboration with Public Health and the grants that are available through State Public Health.
d) bring in local specialists or use telehealth
e) Helpful to have a connection to a larger medical facility in Denver.

Theme: New Medical center/ Healthcare Improvements/ Expanding care

a) Tricia M: *New Medical Center as envisioned near the Pearl Property.*
Aspen has done a great job with this. As we all get older, we need medical facilities in close proximity. I fear my family will have to leave someday as my significant other requires constant medical care which we are currently receiving at the Mayo and Mercy in Durango.
b) ensure local providers accept Medicaid & CHP+
c) We are seriously lacking Pediatric care
d) Urgent Care option or just more availability to a physician in the high season
e) A local facility with a broader array of services, both preventive and basic
f) Keep TMC Primary Care and the ER as one unit
g) Communicate the importance of the medical center in town. Stop letting the people who are here for half the year decide about the health services of our permanent residents
h) Need affordable health care
i) Add more services. Would be so great if we had regular ortho care here, and people didn't have to travel for it. Or pediatric. Or ob/gyn. And mental health, and dermatology. Etc.
j) Also, in my ideal world, acupuncture, homeopathy, chiropractic, herbal therapy, massage, etc. would be covered with insurance!

Response to comment about improving TMD: The Telluride Medical Center is bringing in a healthcare coordinator who will monitor patients with chronic diseases and make sure they follow prescribed regimens. Health educations is being offered to chronically ill citizens via teleconferencing with St. Marys. Periodic health

events are conducted to offer low cost physical exams and other screenings. I am not sure how else we can "improve".

The Telluride Medical Center is awesome, because the practitioners have adapted over the years to the changing desires of patients. There is integrative medicine, and more alternatives offered to standard allopathic care. The more we do this the better. I do think that classes like Lynn Mayer teaching nutrition classes at the library are hugely beneficial, and we need more, more, more of them. Classes on stress management would be good too, but I don't if people would attend, like they do nutrition classes.

Theme: Wellness/Education on services available and healthy living/New recreation center

a) Blythe S: I can't think of a better idea to improve our health than through our diet and exercise. A rec center and health food store could provide this.
b) More affordable programs offered by the recreation center
c) Produce guide or provide 211 for all services/entities that offer health & wellness services to educate community on what exists, financial requirements, & other pre-reqs for participating
d) Marlene S: Use summer months to conduct a series of town hall meetings
e) assist individuals in enrolling in insurance programs
f) The best ways to improve health are through education and better distributors of food.
g) Educate local Employers or Human Resource Departments on what employee health insurance covers, so they may explain to their employee's company benefits. So many people do not fully take advantage of their coverage. By having the patient understand what medical care is available would expand the chances of improved health care.
h) Improve diets and lifestyles.
i) Attract good professionals who have a stake in the community. Change the culture to one that embraces wellness.
j) Access to exercise and screenings. However, I am not particularly interested in getting my services here. I have established relationships with doctors in my hometown.
k) Add a rec center that has all the attractive ways to exercise.
l) I would like to see a Rec Center that is affordable for working residents.
m) Continuing education presentations at the library with Q&A sessions are helpful. Getting people involved in their own healthcare via patient portals, education material and access to their Primary Care provider allowing them to make their own healthcare decisions will help improve their health and well-being.
n) Community center
o) Outreach in the communities who do not have access to health care, care managers to help residents navigate through the health care system, collaboration and better communication between community health care providers.

QUESTION 5: OVERCOMING OBSTACLES TO CARE

We asked: How can the Telluride community better care for those who have obstacles to healthcare? The general response to this question was that there are many services available, but there needs to be more education on how to access these services and what people are eligible for. Also, for those who do not have healthcare currently, many suspect federal healthcare reform will fix this. This question was asked on the TellurdieHealthIdeas site and the online survey.

Theme: Current programs and services are serving the needs, but we can improve education on what is available

a) Sharon G: *Maintain current projects for the underserved*
With the help of the Telluride Foundation, Tricounty Health Network, Telluride Medical Center and San Miguel County Nursing locals in the region have access to help with insurance enrollment, non-

emergency transportation, dental screening for the young, sliding scale clinics, health fairs, local community health workers, a clinic that takes Medicare and Medicaid. We are fortunate however it remains a struggle to maintain these valuable assets.

b) Marketing what is available through the Daily Planet, etc.
c) Ongoing community education
d) We need to make sure all that will be gaining health insurance understand their options. If they do not understand their options, they will most likely get something they do not need or want. Also, if the clinic would lower prices, it would be more reasonable to be a patient there. I only go there for things that I absolutely need done.
e) Better education of what is available. For example many of the younger population's high cost medical bills come from an injury and they are not insured. If they were to get just an accident policy they could avoid some of these high cost bills and accident insurance is affordable
f) Better education on the importance of having planned to cover healthcare costs and resources explaining different options available
a) Public Service campaigns by the community and social services to educate the community
b) More public forums of discussion- such as newspaper articles, "how to" work shops, a designated person within the community who can be easily accessed
c) Having a resource guide available to all would help

Theme: Expand services and scope

a) Stuart F: *Broaden our scope.* We have very little community focus on seniors, which should be expanded. That population is growing and with an average age in Telluride in its mid-30's we need to make sure that seniors feel that they can also get excellent advice and care.
b) Transportation to specialists in Montrose, Durango and GJ could be helpful, however, the Telluride Medical Center is striving to bring visiting specialists to Telluride each month. The only barrier is the willingness of some specialist to come to Telluride - perhaps a community subsidy might expand this program.
c) Write Grants for financial assistance for The Medical Center! TMC is a non-profit organization, currently there is one generous Donator who gives TMC a large amount of funding, but they have chosen only to allow it to Hispanic population.
d) Organize an insurance co-op to reduce costs
e) A mill levy for the new facility. Enough to take care of those in dire need but not enough to socialize medicine in Telluride.
f) Access to govt programs supplementing income/ food distribution/ health care
    1) Have a financial hardship program
    2) Have a Care Coordinator in Primary Care
    3) Have obs beds
    4) Have minor surgery capabilities
    5) Have home health care
    6) Have complementary medicine

Theme: Support of federal healthcare reform

a) I support a federal safety net for all citizens when it comes to healthcare
b) With Obamacare coming to CO, we should be able to increase our coverage of residents and visitors alike. The facility would become a magnet for preventive care and health fairs that raise awareness and access
c) Medicaid is there for these folks, as well as Obamacare
d) Socialized medicine! Single payer reform!
e) Reform is needed that subsidizes indigent care by the federal government
f) Medicaid will be expanding under the AHCA

Original idea

On a more visionary scale, if Telluride wants to lead by example, I am curious as to what it would cost for the community to "self-insure" itself. For example, I pay over $5,000/year in health insurance. I would gladly give that to a local health care provider to provide me with basic services and cover my services needed outside the community, when necessary. If the Telluride region has 7,000 people and half of them sign up for this service, that's over $17 million, the majority of which would stay here in the community.

What is the word or phrase you would use to describe health, healthcare and wellness in the Telluride community? (MindMixer & Constant Contact)

Active	Excellent	Isolated
Active	Excellent	Longevity
Adequate	Exercise	Magnificent
Adequate	Expensive	Minimal
Basic	Expensive	Nutrition
Basic	Expensive	Patched-together
Caring	Expensive	Poor
Community	Happiness	Preliminary
Community	Health-conscious	Quality
Compassionate	Healthy	Responsible
Critical	Healthy	Small
Do we have one?	Healthy	Vibrant
Engaged	Hypocritical	Well-intended
Essential	Improving	Wonderful

Voting on healthcare services (MindMixer & Constant Contact)

Health care service	Number who voted
Primary Care	37
Dermatology	35
Mental/Behavioral Health	31
Women's Wellness/OBGYN	26
Dentistry	25
Alternative Medicine	24
Pediatrics	24
Physical Therapy	24
Orthopedics	22
Telemedicine (video access to specialists and services)	20
Substance Abuse	17
Cardiac/Heart Care	16
Chiropractic	16
Optometry/Eye Care	13
24 Hour Pharmacy	11
Emergency Care*	11
Hospice/Palliative Care	8
Oncology/Cancer Care	8
Gastroenterology	4
Neurology	4
Orthodontics-	1

*Not included as an option to vote on in online survey

Comments on this question about services:

- Most of these already exist in some form in Telluride. Others are one hour away.
- Also, just because the services should be provided does not mean they should be provided at a central facility.
- I have established relationships with all of these services in my hometown -- these are top notch. Furthermore, people here can get these services in Montrose and Grand Junction. There is no reason to duplicate them here.
- Some of this seems kind of ridiculous to consider... I don't see us having oncology here. Or even hospice, really, given the demand.
- Need to add mammography/DEXA

Summary for Internal Use
Telluride Health Ideas Public Engagement Website
Round Two Summary

The Telluride Foundation launched a public engagement initiative focused on health and wellness issues, including future programs and/or facilities to support the community's vision for health in the area. Round two of questions launched on Friday, July 5th and had a soft ending on Monday, July 22nd. The questions and specific areas of emphasis were developed in collaboration with the Telluride Foundation and stakeholder interviews. Most of the questions in this second round read much like a survey, providing users with a select set of answer choices. The open-ended, idea generation items asked users to submit a photo of what a healthy telluride means to them and one word to describe Telluride. These two questions were also included in round one.

Telluride Health Ideas Page Activity

- 2,914 page views (up from 2,849 page views in round one)
- 709 site visits (up from 303 site visits in round one)
- TellurideHealthIdeas.org has 75 registered site users (up from 62 users during round one). Only users who registered may comment, vote on ideas and participate in polls. Zip code, age and gender are required to become a registered user on the site

TELLURIDEHEALTHIDEAS.ORG & CONSTANT CONTACT SURVEY RESULTS

Twenty-six ideas were submitted online by users representing a range of views, perspectives and backgrounds. Twenty two users responded to the Constant Contact survey sent out. Both platforms had identical questions and slight variations in answer choices offered. This section summarizes the ideas raised by users as well as the results of the survey questions that were asked. Responses to surveys are ordered by most votes to least votes.

QUESTION ONE: WHAT DOES HEALTH AND WELLNESS IN TELLURIDE MEANS TO YOU

1. Which of the following are important to incorporate into a Telluride Health & Wellness Center?

Nutrition/healthy eating counseling	18 votes
Mental/Behavioral Health	16 votes
Physical Therapy	14 votes
Exercise Physiology	13 votes
Sports medicine	13 votes
Substance Abuse	12 votes
Alternative Medicine	11 votes
Women's Wellness	11 votes
Lifestyle coaching	10 votes
Telemedicine (video access to specialists and services)	10 votes
Chiropractic	8 votes
Altitude Physiology**	6 votes
Acupuncture	6 votes
Weight loss counseling	6 votes
Other	2 votes

** Option not offered on MindMixer site
OTHER: Financial wellness

COMMENTS:

- There already are good physical therapists here; Medical Center should not impede on these service. The same for acupuncture. Focus on services that ARE NOT available, which have been checked above.
- I have posted this in other areas on the site. I cannot stress enough about how vital this is in any wellness plan. The results I have seen myself - drastically reduced stress, resulting in drastically reduced health issues.
- "The new world of healthcare reform" ?...unproven, untested and mostly a self-responsibility. No "Center" will work for the poor or the responsible intelligentsia. Pie in sky expensive waste.
- None of these need to be combined unless they are located in the same or nearby building. No operational or legal combination is necessary or necessarily desired.

2. Given that Telluride is too small to support every service, how can we improve the ability for people to access health care services elsewhere?

Telemedicine	18 votes
Public transportation	10 votes
Private ride share	4 votes
Other	5 votes
We don't need to make any changes to access care*	2 votes
None of the above	2 votes

*Option not offered on Constant Contact survey

OTHER:

- Visiting specialist several times a month
- Part time doctors
- Improve the Medical Center
- Provide a location that is easily accessible year round to all patients
- Education

COMMENTS:

- I don't think there should be a problem unless it is an elderly or sick person who lives alone. The community usually steps in to help these people.
- We need to provide the facilities and financial incentives so more specialist spend time in Telluride on a regular basis e.g. Dr Singh for orthopedic. Also, empty nester or semi-retired doctors who want a shorter work week and/or a better quality of life should be recruited.
- I personally had a very negative experience at the Medical Center and doubt I would ever return. The doctor & nurse were fantastic. Everyone else - SCARY. If you want good health care then the wellness side has to mesh with the medical side, in a way that doesn't terrify everyday citizens.

3. It is important to have an emergency helicopter ("Flight for Life") landing area:

Immediately adjacent to the Telluride Medical Center	25 votes
At least 15 minute drive away from the Center	4 votes
Not necessary	0 votes
Other	0 votes

COMMENTS:

- It may be more important to have an emergency helicopter close to the ski area. How many ski injuries require it vs. other injuries?
- Define 15 minutes? Maybe 5 minutes... with only one road in and out of town this leaves too much risk to a critical situation.
- What do the experts say?
- Is 15 minutes too far?
- Ponderous obviousity.
- BY Christine O: Why have you left out one of the biggest factors to wellness? Financial Wellness! The statistics are staggering. 70% of American's experience stress related illnesses (US Department of Health and Human Services). Sever and prolonged stress in financial in nature can have a serious effect on a person's physical and mental health (Consumer and Family Sciences of Purdue University). In a LinkedIn survey 64% said that finance is the biggest cause of stress in life. And, 40% of employees admit that stress over money negatively affects their productivity.

QUESTION TWO: TRAVELING OUTSIDE OF TELLURIDE FOR HEALTHCARE

1. Why do you go outside Telluride for health and healthcare services?

Service not offered in Telluride	21 votes
Prefer outside provider	10 votes
Specialist recommended by primary care provider	8 votes
Local provider is not in health plan network	5 votes
I don't travel outside of Telluride for healthcare services*	1 vote
Other (preference and proven expert sources)	2 votes

*Option not offered on Constant Contact survey

COMMENTS:

- Only go outside Telluride for Gyn.
- We need more board certified doctors. Some local docs are not board certified in the specialties we need, so we travel.
- The medical center scares me.
- World class specialists are desired by affluent residents.
- I prefer to get all my care in Telluride to the degree possible. The providers here are first class, their care is excellent and I don't have to wait to be seen. Waits of up to 2 hours are not uncommon at the Stedman Clinic when I went there for specialty care.

2. **When you leave Telluride for health and healthcare services, what preparations and or considerations do you make?**

Travel time away from home	19 votes
Travel costs	16 votes
Time off from work	13 votes
Transportation issues (public transportation, ride- share, medical shuttle)	3 votes
Not applicable to me*	2 votes
Childcare Arrangements	1 vote
Other	0 votes

*Option not offered on Constant Contact survey

COMMENTS:

- The medical facilities have world class physicians for heart, cancer and wellness.
- The dominant factor is the quality of care. We travel and spend the time to get better docs.
- This is part of living in a small community.
- Sure it costs to go outside of Telluride for care but anytime I would go for specialty care in the big city, I would have to take time off work.

3. **When you leave Telluride for health and healthcare services, what other things do you combine the trip with?**

Groceries	21 votes
Shopping*	18 votes
Eating out	14 votes
Other Appointments*	12 votes
Entertainment	6 votes
Business meetings	5 votes
Need to leave valley	5 votes
None of the Above	3 votes
Other	1 vote

*Option not offered on Constant Contact survey

COMMENTS:

- Telluride will always be a second home for me.
- Norwood
- We spend thousands in Montrose that we would rather spend in Telluride.
- All trips to Montrose, GJ or Durango are planned for multiple needs.
- I do this regardless - I don't shop, grocery shop, or eat out here.

4. Would you use similar health or healthcare service offered in Telluride if:

Telluride providers were similar in skill and quality as outside provider	17 votes
Care was covered as "in-network" for my health plan	14 votes
I am unwilling to change provider	5 votes
Other	3 votes
Not applicable to me*	1 vote
Other**	1 vote

*Option not offered on Constant Contact survey
** Option not offered on MindMixer site

COMMENTS:

- While I appreciate what you are trying to do, the specialists that I have access to would never be available here.
- Would much prefer to have all of my health services based in TELLURIDE
- It is not likely we can ever financially justify highly skilled specialists. We have highly skilled primary care and ER physicians.
- I would certain use the specialist in Telluride if it was for a service they were qualified to perform. For instance, I would not have a joint replaced here, cardiac or neuro surgery here etc. General surgery, peds, ob/gyn, minor orthopedics okay but really not much else.

5. The elevation of Telluride affects:

None of the above	13 votes
Exercise	6 votes
How long I plan to live in or visit Telluride	6 votes
Sleep	6 votes
My daily life	4 votes
It does not affect me	1 vote
Other	1 vote

COMMENTS:

- Living in Telluride improves all of the above!
- Only a positive good air quality
- It's fine
- Once retired, I plan to spend the winters where it is much warmer and has NO snow!!!
- COMMENT BY Karen D: There is excellent doctor service and nursing staff at Telluride Medical Center. We wish we did not have to travel so far for specialist services, such as neurology, rheumatology, and gastroenterology.

QUESTION THREE: HEALTHCARE SERVICES OFFERED

Which of the following health and healthcare services do you use that are currently offered locally within Telluride?

Primary Care	16 votes
Physical Therapy	13 votes
Dentistry	12 votes
Optometry/Eye Care	7 votes
Chiropractic	6 votes
Orthopedics	4 votes
Mental/Behavioral Health	4 votes
Alternative Medicine	4 votes
24 Hour Pharmacy	3 votes
Women's Wellness OBGYN/Pre-natal	1 vote
Substance Abuse	1 vote
Ear, nose and throat	1 vote
Pediatrics	1 vote
Cardiology	1 vote
Dermatology	1 vote
Telemedicine (video access to specialists and services) and Allergist	0 votes
Other	1 vote
None	1 vote

COMMENTS:

- Emergency care. Also, because I am here for 3 to 4 months in the summer, I have used the physical therapy (Peaks Performance) which is outstanding.
- Faulty question- some of these are not offered. If they are, it is a secret

Which services do you currently leave Telluride for?

Dermatology	12 votes
Optometry/Eye Care	8 votes
Orthopedics	7 votes
Women's Wellness OBGYN/Pre-natal	7 votes
Primary Care	6 votes
Dentistry	5 votes
Ear, nose and throat	4 votes
Allergist	4 votes
24 Hour Pharmacy	3 votes
Mental/Behavioral Health	2 votes
Other	2 votes
Cardiology	2 votes
Alternative Medicine	1 vote
Pediatrics	1 vote
Physical Therapy	1 vote
Telemedicine (video access to specialists and services)	1 vote

Chiropractic	1 vote
None	1 vote
Substance Abuse	0 votes
Other	4 votes

OTHER: Mammogram and Colonoscopy; Orthodontics; Urologist; Pharmacy

When you leave Telluride for health and healthcare services, where do you go?

Montrose	15 votes
Grand Junction	12 votes
Durango	10 votes
Denver*	1 vote
Not applicable to me	1 vote
Other	8 votes

*Option not offered on Constant Contact survey
OTHER: Norwood; Norwood; Basalt; Vail Valley MC- Stedman Clinic; Chicago; Los Angeles; Arizona

Which services would you expect to leave Telluride for, even if they are currently available locally or they became available locally? Why?

Cardiology	9 votes
Primary Care	6 votes
Women's Wellness OBGYN/Pre-natal	6 votes
Dermatology	5 votes
Orthopedics	5 votes
Ear, nose and throat	4 votes
Optometry/Eye Care	3 votes
Dentistry	2 votes
Allergist	2 votes
Mental/Behavioral Health	2 vote
Physical Therapy	1 vote
Alternative Medicine	1 vote
Other	7 votes
None	1 vote
Pediatrics, Telemedicine (video access to specialists and services), Substance Abuse, Chiropractic, 24 Hour Pharmacy	0 votes

OTHER: Mammo/colonoscopy; Ooncology, radiology; Gastroenterology; Pharmacy

COMMENTS:

- None if competently offered
- BY Julie W: With any serious condition, I would prefer to be in a bigger facility that specializes in the treatment.

QUESTION 4: TELLURIDE SHOULD BE KNOWN FOR…

If Telluride were known as a center of excellence in health, wellness, or healthcare, what would that look like to you?

Website responses:

- **Broader than just a building**
  Idea by Mark B: A center of excellence in health would be more than a building but a multi-faceted health and wellness ecosystem that would be center on the new facility but include other facilities in the region such as the Peaks for physical wellness. The goal should be to attract those who are seeking an awakening in health to Telluride to grow the tourist base. Seminars, panels, ropes course, spa, spiritual guidance, etc. should be part of this new ecosystem of wellness. Think broader than a clinic.
- **Putting a new facility around the existing excellence**
  Idea by Julie W: We have so many talented providers in this area it would be a challenge not to offend existing providers by limiting access. The facility would need to have one stop access with choices of providers.

Constant Contact responses:

- Having a presence in schools for nutrition, substance abuse and mental illness/depression detection. Access to Flight for Life for the vehicular and adventure/recreational accidents that occur in town and in the backcountry.
- A "center" with experts who organize and teach wellness.
- Primary care, ER services, Search and Rescue, EMT services, Integrative Medicine, Integrative Pharmacy, Life Coaches, Mental Health Services, Physical Activity Coaching/programs, Medical Transport to Montrose, Grand Junction, and Durango. Employment/Career counseling - without a job/roof/food, health and wellness will not be a priority.
- I don't see it. Most people are going to seek advanced medical attention in Grand Junction, Denver or a larger city. I can't see how it would work economically in a size this town; you will not have the volume to attract the best specialists.
- A regional center that would draw from the whole four corners. Pull people in from Montrose, Durango and Grand Junction because of breadth and quality of service. Like Vail does for Front Range.
- I would love to have an affordable exercise facility in Telluride with cardio and strength conditioning options available.
- Become nationally recognized or known in a few key practice areas that are relevant to our area (e.g. orthopedics, altitude, sports medicine, etc.), and become competent to retain more locals in the other practice areas of medicine.
- Not much different. To me it looks like pure recreation. People don't come here to get "healed" they come here to play.
- Available year round near the center of population. Not reliant upon the gondola. Near pharmacies and other doctors.
- Not important to me. I want basic and emergency services and don't expect too much in a county that does not even have a traffic light.
- No idea… ideological impractical concept.
- Great Primary Care and Emergency physicians who can hand off medical needs to specialists in Montrose, GJ and/or Durango - we have that now.
- Really not much different from today. No world class specialist is going to risk a 7 digit income to come to Telluride to set up shop. We can have the complementary medicine elements but I don't see that a 'quality' surgery center is financially feasible with the low volumes we would have. We could get all excited about have the Mayo Clinic de Telluride and over build just to have the carrying cost down the road. I appreciate the care with which you are going about your study and hope that the right answers will be borne out in the end.

QUESTION 5: TELL US WHAT YOU THINK

What other thoughts do you have on the potential for a new health and wellness center in Telluride?
Website response:

- **Alternative Medicine**
  Idea by Mark B: Given Telluride's history and alternative lifestyles, I believe any new facility should include a 'center for alternative medicine'. Such a 'center' could sponsor conferences and bring other like-minded people to town. One must look at the clinic as more than just a building but a catalyst for bringing new people to town and provide current residents with other forms of medicine outside the mainstream.

Constant Contact responses:

- These are food for thought: How do current programs work to turn around the drunk/stoned homeless community members' lives? How do current programs work to comfort the non-Anglo, Hispanic communities who run the kitchens and laundry facilities for resorts.
- I don't think a fat farm will work here, if that is what you are thinking. The altitude is too much of a challenge.
- I want to be armed with the knowledge needed to make the best choice for myself and my family when it comes to our health care coverage, but when I review the various health care plans that exist today, I find the whole process overwhelming and daunting. I think it would be helpful if there was someone in this region who didn't work for an insurance company (or get a kickback) but had the knowledge and experience to assist and educate individuals about their health insurance options in such a way that makes sense - laymen's terms. The health insurance companies I have dealt with(CNIC, BC/BS, UnitedHealth) use too much industry jargon, and don't always share all the pertinent information needed to make an educated decision. To have someone in this region who can cut through the fine print and really tell me what I will receive with plan x, y and z would be well worth the consultation fee.
- A very important consideration is the urgent care we provide our visitors. The tourists drive our economy and making a bad experience (e.g. injured while skiing) as pleasant as possible will have a huge multiplier effect for us. Currently, an injured skier endures a sketchy toboggan ride, to then be put in a junky old van for a bumpy drive to a loading dock. After recovering, the patient has to walk or find a ride back to the gondola or their rental unit (many haven't rented a car and we don;t have reliable taxi service). Our locals will always be able to figure out how to find the local health care; our tourists who have a bad experience may never come back. We need a ski-in ski-out, gondola accessible facility with lots of parking and services to ensure our guest have a great urgent care experience.
- Sorry to keep repeating - but I'm not sure where all this data is going. I believe there has to be a piece on financial wellness - not just because this is how I make a living; but, because of the results I have seen with my clients who are able to obtain that financial wellness. And how it significantly lowers their stress levels, and significantly helps their overall health - mental and physical.
- It needs to be in Telluride not in an area that cannot be reached readily by walking, bus service or bicycling.
- Bigger is not always better. Do a few things and do them well. If one were to move to a town the size of Telluride and expect a cardiologist you really need a psychiatrist.
- Forget about it.
- The primary need is to build a new long lasting Medical Center. The rest is window dressing.

What is the word or phrase you would use to describe health, healthcare and wellness in the Telluride community? (Only asked on the website, NOT constant contact)

Active
Active
Adequate
Adequate
Basic
Basic
Caring
Community
Community
Compassionate
Critical
Do we have one?
Engaged
Essential
Excellent
Excellent
Exercise
Expensive
Expensive
Expensive
Expensive
Facility
Financial-wellness
Happiness
Health-conscious
Healthy
Healthy
Healthy
Hypocritical
Improving
Isolated
Longevity
Magnificent
Minimal
Nutrition
Out-patient-facility
Patched-together
Poor
Preliminary
Quality
Reliable
Responsible
Small
Vibrant
Well-intended
Wonderful