2014 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, 2014 and with Information about Prospective Years

Evaluation Committee

Telluride Hospital District Board President

Larry Mallard — Date: 1-29-15

QA Committee THD Board Member

Carol Kammer — Date: 1/29/15

Emergency Service Medical Director

Dr. Diana Koelliker — Date: 1/30/15

Primary Care Medical Director

Dr. Sharon Grundy — Date: 1/31/2015

Primary Care Mid-Level

Eric Johnson, NP — Date: 1/30/15

Telluride Medical Center Executive Director

Gordon Reichard, MHA — Date: 1/30/15

Contents of the Annual Report are as follows:

Attached Exhibits

Exhibit A – Executive Director's Report
Exhibit B – 2014 Financial Annual Report
Exhibit C – 2013 Dalby Wendland Audit Recommendation Letter, 2013 Management Discussion and Analysis and 2013 Audited Financial Statements
Exhibit D – 2014 Annual Operating Budget
Exhibit E – Mill Levy Actual & Projected
Exhibit F – Assessed Value & Mill Levy History
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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 2014. The evaluations and audits presented to the Telluride Hospital District Board of Directors constitute the "State of the Telluride Medical Center."

2014 Highlights

- Developed and implemented a new facility site selection process
- A Community Advisory Committee was established to assist with the site selection process
- The Telluride Hospital District Board selected a new facility site in the Town of Mountain Village
- A Task Force was established to explore the development of local Hospice, Palliative Care and Home Healthcare
- The Carol M White Physical Education Program Department of Education grant expired October 31, 2014
- Committed to expand to a fourth primary care provider and MA two days per week in 2015
- Started Shared Savings with four Comprehensive Primary Care Initiative (CPCi) payors, January 1, 2014

The TMC Foundation under the direction of Kate Wadley retained a capital campaign consultant in anticipation of a 2015 fund raising campaign in support of a new facility.

After a 10% reduction in THD's 2012 mill levy, a 1.3% cut in 2013 and an additional 18.8% cut in 2014, TMC had another solid financial year. In 2014, Primary Care (PC) and the Emergency Department (ED) visits were up by 12% and 9% respectfully over 2013.

Over the last year, all the Telluride economic indicators have been positive. Telluride's occupancy rose 3% over 2013 and the 2014 real estate dollar volume sales were up by an impressive 72% over 2013. During 2014, building permits increased by 19.2% in the town of Telluride. Looking forward, the expansion of Medicaid will significantly increase the number of PC and ED visits in 2015. Based on TMC's 2014 performance and the local economic indicators led TMC management to project a budgeted 3% increase in visits for Emergency Services and a 7% increase in patient visits for Primary Care in 2015. "It was a year of record-breaking sales tax and a construction boom" according to the 12/31/14 Telluride Daily Planet.

Of concern in the near future is the limited space in which the TMC Primary Care providers have to see patients and the restriction that places their ability to squeeze in last minute urgent care patients in Primary Care.

2014 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 plans for the coming years.

II. **District Description – General Information**

a. Board Members, Officers', Titles and Terms

Board Member	Officer	Title	Term Expiration Year
Larry Mallard	Yes	Chair as of Jan, 2014	May 2016
Dan Garner	Yes	Vice-President	May 2016
Andrew Karow	Yes	Treasure	May 2018
Carol Kammer	Yes	Secretary	May 2018
Richard Cornelius	Yes		May 2018

b. Changes in board membership in the past year
- Mr. Larry Mallard assumed the board Chair in January 2014. Andrew Karow, Carol Kammer and Richard Cornelius were duly elected May 6, 2014.

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
- THD Board canceled the May 6 2014 Special District election for three seats due to a lack of candidates. Proof of Publication of election cancelation was printed on March 28, 2014 in a legal newspaper.

III. **District boundary changes for the report year and proposed changes for the coming year**
- There were no THD boundary changes in 2014 and none anticipated in 2015.

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.
   - THD has no extraterritorial services, facilities and agreements

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 2014.

b. List projects under construction with anticipated dates of completion/operation.
   - No "projects were under construction" within 2014.

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 2014.

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 in 2014.

VII. Financial Activities, Plan and Report

a. TMC's 2014 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 2014 Management Discussion and Analysis. The 2013 Audited Financial Statement, Letter and the Management Discussion and Analysis are provided.
     - See **Exhibit C** – DWC Audit Recommendation Letter
     - See **Exhibit C** – 2013 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 2014. Actual and projected mill levies are shown in **Exhibit E.**
f. Provide detailed information on each authorized unissued debt obligation (include ballot issue letter designation and election date, amounts authorized and un-issued, purpose).
   - THD had no unissued debt obligation in 2014
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 payment is - $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 2014
   iii. Describe any notice of default of any District financial obligations
      - THD had no default of any financial obligations and therefore sent no notices of such
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 2014.

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 2014. However the District *may* issue an undetermined amount of General Obligation debt at the November 2015 Tabor election.

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

The TMC Foundation was established in 2008 largely for the purpose of a capital campaign for a new facility. The District plans on a replacement facility within the next 60 months therefore the purpose of the Foundation has come to fruition. See the 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 medical direction of Dr. Sharon Grundy 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 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. Daniel 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 2014.

Primary Care

- No new or revised policies and procedures in 2014

Trauma and Emergency Services

- The Interpretation Services in the ER was updated with a new interpreting service and staff interpreters
- Incorporated the Occurrence Reporting to the ER policy manual from the HR manual
- Created a new policy for Restraints for Violent and Non-Violent Patients
- Created a new policy regarding Transient Internal ED Diversion

Clinical Laboratory

- No new or revised policies and procedures in 2014

Radiology

- No new or revised policies and procedures in 2014

Patient's Business Office

- When to send patients to collections if they receive payment from insurance
- Implemented a No Show/Cancelation policy for PC appointments

Administration

- Revised the Authority and Staff Responsibilities policy

Human Resources

- Revised the following HR policies and procedures:
    - The policy pertaining to the Employee Handbook
    - Alcohol & Drug Free Workplace

- HIPAA – Employee
- Conflict of Interest – Employee
- ASAP Employee Set-up
- Data Security and Use of TMC Equipment
- Healthcare Coverage-Employee
- Benefits Physician Employees
- Educational Assistance
- Universal Precautions & Infection Control Training
- PTO Donation
- Evaluations
- Impaired Providers

Environment of Care

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

XIII. 2014 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 conducted a new medical center site selection process over 2014. After much deliberation and public input, the Board selected the Town of Mountain Village Town Hall Site.
2. THD/TMC continued affiliation with St. Mary's Hospital in Grand Junction
3. The Carol M. White Physical Education Program was completed in 2014
4. Richard Cornelius joined the THD board, replacing long time board chair Albert Roer
5. Social Detox is planned for the new facility to replace the county jail
6. The proposition to permit the development of the RV Lot for a new medical center was roundly defeated (32% for) in the November 5, 2014 election
7. TMC is on fiber telecommunications
8. Data Center is now protected with a waterless fire suppression system

Primary Care (PC)

1. THD approved the addition of a mid-level provider two days per week in Primary Care beginning January 5, 2015
2. Keeping PC open all day on Saturday's
3. Achieved all 2014 Comprehensive Primary Care Initiative (CPCi) Milestones;
4. Primary Care's Electronic Medical Record (EMR) achieved Phase II Meaningful Use status
5. October Health Fair was poorly attended and will be the last year

6. Continued HRSA grant for Diabetes and CVD
7. PC volume up by 12% over 2013
8. Lab inspection occurred with no deficiencies
9. Hired BHC and 4TH provider
10. Employ Christine Tealdi to assist Paula Scheidegger with Patient Care Coordination as funded by CPCi
11. Establish a two way interface with CIIS (the states vaccination record keeping system)

Emergency Department

1. Met quality measures in Emergency Department (ED) and Primary Care
2. Passed Level V designation
3. Hosted the regional Certified Emergency Nurse (CEN) course
4. TMC Pharmacy was inspected with zero deficiencies

Radiology

1. New PACS so providers can access images from anywhere

Patient's Billing Office

1. Did match Medical Group Management Assoc benchmark for days in A/R

Telluride Medical Center Foundation

1. Assisted in organizing and hosting the 2014 Play for Pink Golf Tournament
2. 2014 End of the Year Appeal was the largest in Foundation history at $135,000

XIV. 2015 Goals

Telluride Medical Center

1. Begin the design, financing and fundraising process for a new facility
2. Improve payor contracts

Primary Care

1. Transition to a modern workflow
2. Seek to see all urgent care patients

Emergency Department

1. Continue emphasizing quality of care by monitoring quality measures
2. 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
Gordon Reichard, MHA
For the period of January 1, 2014 to December 31, 2014

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 2014.

Over the last year, the Telluride economic indicators have been positive. The Telluride Daily Planet newspaper reported in their 1/2/15 issue that "It was a year of record-breaking sales tax and a construction boom." Looking forward, we believe Medicaid expansion under the ACA will continue to increase the number of PC and ED visits in 2015. Based on TMC's 2014 performance and the local economic indicators, TMC's management projected a budgeted increase of 3% in visits for the Emergency Department, a 7% increase in patient visits for Primary Care and a 3% increase in charges in 2015. We believe we will see this increase because the projected 2015 tourism visits are running well ahead of the record 2014 visits; Primary Care (PC) added a provider two days per week in 2015 and the Emergency Department still have excess capacity.

Financially TMC exceeded its projected 2014 net revenue by $145,322. Please see **Exhibit B** for further details.

2014 has seen the following program accomplishments:

- 2014 finally brought some movement for the Telluride Hospital District on finding a new building site. The THD Board has been actively searching for a site since 2006 and through a series of steps they have identified a site in the Town of Mountain Village suitable to build a new facility of up to 50,000 square feet. Site Selection process kicked off in March 2014 with pre-meetings with property owners who held suitable large enough property. A Request for Information (RFI) was released March 18 that was designed to collect information from which to evaluate the relative merits of the parcels. Three property owners responded to the RFI – Big Dog Holdings (in Lawson Hill), Lawson Hill Property Owners Association and the Town of Mountain of Mountain Village. The Town of Telluride did not respond to the RFI but instead held a referendum asking the town's electorate if they would approve the building of a new medical center on the RV Lot on the west side of town. The referendum only received 32% support and thus the opportunity for the medical center to remain in the Town of Telluride was closed. Planning for the new facility will take place over the next 18 months with a community advisory group assisting the THD Board. The THD Board was responsible for holding three Public Forums to address concerns of the District about the site selection process. The Board's goal was to conduct an open, fair and transparent site selection process.
- TMC conducted a test helicopter flight to the proposed building site in Mountain Village in November. Data on decibels and rotor wash wind speed was collected.

- The "Comprehensive Primary Care Initiative" (CPCi) Shared Saving Program began January 1, 2014. This program is based on the Primary Care's ability to control the cost of global healthcare expenditures for their empanelled patients. Accounting for shared saving is done a year in arrears so TMC-PC will not know how they fared until March, 2015 at the earliest.
- TMC-PC added a Behavioral Health Counselor to their providers January 1, 2015.
- The U.S. Department of Education's Carol M. White Physical Education Program (PEP) that TMC administered in San Miguel County's two school districts ended October 31, 2014. Notable improvement was seen in the health and exercise tolerance of the District's students. One of the goals of the program was to educate the students about healthy eating and habits which is hoped will stay with them for a lifetime – thus impacting future generations.
- During the fall of 2014 the board approved the addition of a fourth Primary Care Provider. The PC has not been able to handle the requested appointments from some urgent care patients thus it is believed that by expanding to a fourth mid-level provider (Christine Tealdi) two days a week, we could satisfy this demand. Space continues to be a major issue. In order to free up enough space for the fourth provider, the Visiting Specialist has been moved to the Conference Room on Monday's and Tuesday's. Saturday hours have been expanded in addition to the fourth provider.
- During 2014, management identified the number of cancelled patient appointments and no shows as an issue. The PC provider schedules were full at the beginning of the day making it difficult for patients when they called for an urgent care appointment first thing in the morning. Thus last minute cancelations and no shows prevented PC from serving the Urgent Care patients by effectively taking away available time slots. This issue was impacting our ability to get in the patients that most needed to be seen. A policy was put in place in October 2014 that charges patients for canceling at the last minute or no showing. Evaluation of the effectiveness of this program will not occur until the first quarter of 2015.
- The THD Mill Levy for 2015 remains flat. With mounting expenses scheduled for 2015, much of the last quarter of 2014 was spent preparing for a budget. With no increase in staff wages over the sixth year, THD authorized a 2% across-the-board staff increase in 2015. Plans are to move to a merit pay and performance based system during 2015.
- In December of 2014, Lynn Borup (TMC's payor relations agent) notified TMC that we are receiving 58% of billed charges from Anthem for Primary Care. THD does not have a contract with Anthem in their Emergency Department precisely for this reason – very poor reimbursement. Lynn will attempt to renegotiate both Rocky Mountain Health Plan and Anthem for 2015.
- January 1, 2015 the ED physicians returned to being self-employed under a Professional Limited Liability Corporation agreement with THD.
- Beth Kelly, the medical center's Communications Consultant has developed a new TMC website effective January, 2015.
- A digital sign was installed in the lobby to communicate TMC news to our patients.

- THD is evaluating belonging to the Community Care Organization (similar to an ACO) that the Western Slope Alliance is forming to deliver managed care to insurance beneficiaries in our area.
- The Tri-County Health Network in accordance with THD began to evaluate a Hospice, Palliative Care and Home Health agency for the District. Implementation is slated for first quarter 2015.
- The October Health Fair was held with poor attendance. Management determined that it would be the last.
- Ebola staff training in donning and doffing of Personal Protective Equipment, screening patient intake check lists were established and the ER held a training exercise to prepare for a possible Ebola patient.

The Following are Ongoing Programs:
The Primary Care, Care Managers continue to monitor call their empanelled patients who are seen in the ER or discharged from the hospital. The patient is followed up with a phone call within 24 hours to determine if they need home healthcare, a follow up visit to PC, additional education, and to check on their health status. PC's highest risk patients are entered into a registry that the patient's provider reviews on a monthly basis to monitor their health status and to set therapeutic goal. When a high risk patient calls for an appointment and there is not any available, the Front Desk contacts the Care Manager to call the patient and determine the best course of action.

The Telluride Hospital District board along with TMC's management worked together to update and further refine the Strategic Plan. The 2014-2015 Strategic Plan can be found on the Medical Center's website – Tellmed.org. The 2015 Strategic Plan update will be released by March.

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. During the past Annual Report period, there has been one high level meeting with the St. Mary's executive team to discuss the performance of our affiliation and the future desired outcomes for the relationship.

EXHIBIT B – 2014 Financial Annual Report
Julie Wesseling, Financial Director

Financially, 2014 was an extremely positive year with patient visit growth exceeding all expectations. The Emergency department visits were projected to remain flat in 2014 but in reality grew 9% and the primary Care visits projected to grow 3% grew 7% as well as ancillary services related to imaging and lab. The most significant change was the addition of care coordination which involves deliberately organizing patient care activities including sharing information among all care providers.

Also worth noting is the decreasing trend in reimbursements relating to contractual adjustments and bad debt. Collectability decreased by 5% overall in 2014 related to the shifting payer mix from commercial payer insurance to Medicaid payer.

Below is a list of the other major unplanned variances.

- An overall increase in the Other Operating income chiefly made up of grant and incentives income. The increasing requirements of the Comprehensive Primary Care Initiative drove revenues higher offset by the decreased Meaningful Use incentives nearing the end of their commitment.
- 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 provide the transformational services required by the CPCi and 3) a major revision to the Medical Assistant job descriptions requiring more advanced skills.
- Supply purchases increased 30% over the previous year purchase prices due to 1) increased supplies driven by increased lab services and 2) increased medication pricing.
- Continued change in the front office staff that left positions open as well as staff changes to PRN from benefitted status.
- Unplanned communications costs relating to the future home of the medical center.
- Continued funding of the rural USAF grant offsetting telephone and internet upgrade costs.

These unforeseen events helped end the year with a $124,000 positive variance from budget.

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 increasing 12% over the previous year-end which represents 30% of the outstanding balance of receivables as compared to 33% of the outstanding balance in 2013.

The Net Days in Accounts Receivable (A/R) decreased one day and increased three days respectively over last year as evidenced by the Emergency Departments (ED) Days in Accounts Receivable (DAR) going from 69 days to 68 days and the Primary Care (PC) Days in Accounts Receivable (DAR) going from 38 to 41 days, respectively. This is attributed to the increased medical visits and payer claims at year end.

Our cash position remains strong. The year-end total cash stands at $2,581,976; a $76,951 improvement over December 2013. Included in this total is Restricted Cash of $875,000 of which $750,000 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 108 as compared to 123 in 2013 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 $945,000.

The overall traffic to the medical center campus increased 10% in 2014 and consisted of 18,525 patients as compared to 16,826 patients in 2013. The Primary Care providers saw 11,077 patients and staff administered 3,922 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 3,526 patients in 2014 an increase of 9.6% over the last year.

Overall, the Medicare and Medicaid (M/M) percentage of our commercial business comprises 27.8% (vs. 19% in the previous year) in Primary Care (PC) and 15.5% (vs. 15% 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 48%.

Another change in payer mix related to worker's compensation. The ED worker's compensation visits increased 10% while the primary care visits increased 8% indicating that the local economy is coming back.

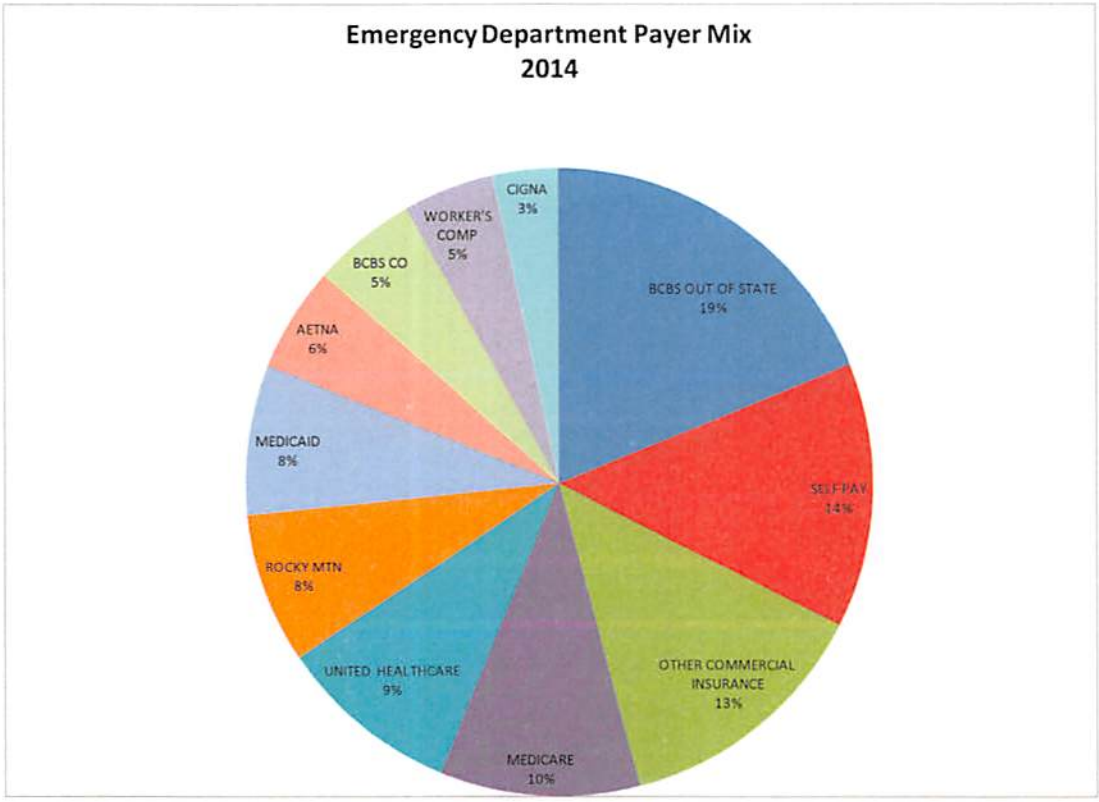
TMC's management goal is to constantly improve operations. In addition to providing electronic access to patients for both medical records and billing information, the Primary Care staff was able to maximize their work towards the federal government's requirements for Meaningful Use (MU). The staff must now focus on MU Stage 2 which has much higher standards. MU during 2014 resulted in incentive payments of $4,000

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 2014 compared to 2013

ED Payer Categories	2014	2013	Difference between Yrs
BCBS OUT OF STATE	$ 654,589	$ 556,405	$ 98,184
SELF PAY	$ 473,072	$ 407,814	$ 65,258
OTHER COMMERCIAL INSURANCE	$ 465,866	$ 319,025	$ 146,841
MEDICARE	$ 357,337	$ 284,202	$ 73,135
UNITED HEALTHCARE	$ 326,844	$ 364,589	$ (37,745)
ROCKY MTN	$ 271,977	$ 199,222	$ 72,755
MEDICAID	$ 266,703	$ 153,290	$ 113,413
AETNA	$ 190,578	$ 143,809	$ 46,769
BCBS CO	$ 186,953	$ 139,924	$ 47,029
WORKER'S COMP	$ 162,887	$ 127,318	$ 35,569
CIGNA	$ 116,466	$ 132,872	$ (16,406)



Primary Care Payer Mix 2014 compared to 2013

PC Payer Categories	2014	2013	Difference between Yrs
ROCKY MTN	$ 754,797	$ 577,203	$ 177,594
MEDICAID	$ 456,239	$ 237,736	$ 218,503
MEDICARE	$ 424,704	$ 287,058	$ 137,646
OTHER COMMERCIAL INSURANCE	$ 330,572	$ 320,564	$ 10,008
BCBS OUT OF STATE	$ 296,678	$ 250,844	$ 45,834
BCBS CO	$ 286,652	$ 335,283	$ (48,631)
UNITED HEALTHCARE	$ 227,598	$ 186,774	$ 40,824
SELF PAY	$ 211,174	$ 204,374	$ 6,800
WORKER'S COMP	$ 145,916	$ 118,689	$ 27,227
CIGNA	$ 141,793	$ 132,746	$ 9,047
GREAT WEST	$ 114,900	$ 119,545	$ (4,646)

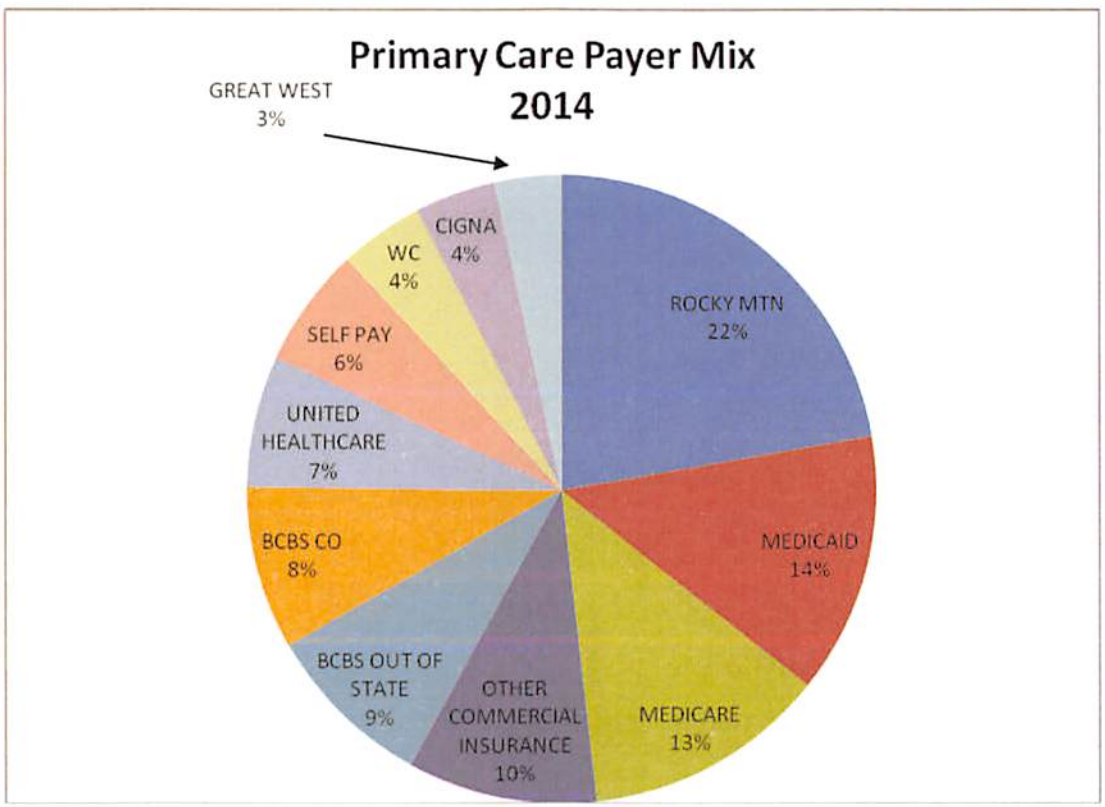


EXHIBIT C – 2013 AUDITED FINANCIAL STATEMENTS

TELLURIDE HOSPITAL DISTRICT

FINANCIAL STATEMENTS
AND
INDEPENDENT AUDITOR'S REPORT

December 31, 2013 and 2012

DALBY, WENDLAND & CO., P.C.

Grand Junction

CPAs and Business Advisors

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), which comprise the statement of net position as of December 31, 2013, and the related statements of revenue, expenses, and changes in net position, and cash flows and for the year then ended, and the related notes to the financial statements.

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 an opinion 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 opinion.

Opinion
In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the blended component units of the District as of December 31, 2013, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Report of Summarized Comparative Information

We have previously audited the District's 2012 financial statements, and our report dated June 19, 2013, expressed an unmodified opinion on those audited, financial statements. In our opinion, the summarized comparative information presented herein as of and for the year ended December 31, 2012, is consistent, in all material respects, with the audited financial statements from which it has been derived.

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 3-6 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.

Other Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise the District's basic financial statements as a whole. The schedule of revenue, non-operating revenues, expenses, and non-operating expenses - departments on page 22 is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relate directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the budgetary information is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Dalby, Wendland & Co, P.C.

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

April 28, 2014

TELLURIDE HOSPITAL DISTRICT

MANAGEMENT'S DISCUSSION AND ANALYSIS

For the year ended December 31, 2013

The 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.

The Telluride Medical Center has two affiliated organizations: the TMC Foundation, a charitable fundraising organization, and IFAM, the Institute for Altitude Medicine, an altitude medicine charitable research organization. For additional financial information on the TMC Foundation, please see the TMC Foundation's December 31, 2013 audited financial statements.

The Telluride Medical Center 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 provides information about the District's assets and liabilities and reflects the District's financial position as of December 31, 2013 and 2012.
- The Statements of Revenue, Expenses and Changes in Net Position reports the cumulative activity of providing healthcare services and the expenses related to such activity for the years ended December 31, 2013 and 2012.
- The Statements of Cash Flows outlines the cash inflows and outflows related to the activity of providing healthcare services for the years ended December 31, 2013 and 2012.
- 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. Statement of Net Position

Financial Analysis

The District's total assets at the end of the 2013 calendar year were $7,467,275 as compared to $7,537,249 at the end of the 2012 calendar year. The $69,974 decrease reflects a decrease in the ad valorem taxes receivable of $284,565, a decrease in the due affiliates of $111,571 related to the timing of payments and a decrease in cash and cash equivalents of $186,259 offset by an increase in a Colotrust investment of $500,466, net accounts receivable from patient services and pledges of $56,524 related to a 9% increase in December revenues, and a decrease in net capital assets of $55,106 related to depreciation. The increase in cash and cash equivalents relates to a 1% increase in net patient service revenue, and a 133% increase in patient related grant revenues. In addition, staff made deliberate reductions where possible anticipating the reduced ad valorem tax revenue.

At December 31, 2013, assets consisted primarily of cash and cash equivalents of $2,376,804, net capital assets of $2,235,965, current year ad valorem taxes receivable of $1,537,313, and net accounts receivable from patient services and pledges of $559,027.

Comparable asset balances at December 31, 2012 were as follows: cash and cash equivalents of $2,563,063, net capital assets of $2,291,071, prior year ad valorem taxes receivable of $1,821,878, and net accounts receivable from patient services and pledges of $502,503.

The District's total liabilities at December 31, 2013 were $869,691 consisting of accrued liabilities of $688,211, and accounts payables and due to affiliates of $172,892. The increase in accrued liabilities of $19,172 reflects an increase in accrued compensation relating to the timing of the pay period end as well as an increase in paid time off balances and the current year's incentive. The decrease in accounts payable and due to affiliates relates directly to the timing of program support from the Foundation to the District.

Comparable liability balances at December 31, 2012 were as follows: total liabilities of $921,922, consisting of accrued liabilities of $669,039, and accounts payable and due to affiliates of $252,883. The 2012 due to affiliates balance included a program expense settlement of $132,227 from the Foundation to the District that occurred early in 2013.

The District's deferred inflows of resources at December 31, 2013 were $1,532,457 and the comparable balance in 2012 was $1,825,470. The decrease of $293,013 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

Patient Service Revenues

The District's net patient service revenue is divided between revenues from its 24-hour emergency service (55%) and revenues from its primary care clinic (45%). However, the emergency service accounts for only 19% of the patient encounters while the primary care accounts for 81%. Eighty-nine percent (89%) of the District's patient charges are billable to insurance companies and 11% 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 which increased between the calendar years 2013 and 2012 by 1%. Net patient service revenue for the 2013 calendar year was reported as $3,820,837 compared to the 2012 calendar year net patient revenue of $3,777,314. Patient visits increased 6% during the same period relating to local office closure and a general improvement in the economy.

The Telluride Medical Center Foundation (TMCF) had a successful year with fund raising of $281,857 in 2013 compared to $302,050 in 2012, which includes in-kind contributions from the District of $102,768 and $104,389, respectively. The decrease does not reflect the program funding to the District which increased to $139,641 in 2013 from $110,176 in 2012. TMCF received grants in 2013 totaling $1,292,719 of which all funds were dispersed per the program. Comparable grants in 2012 totaled $1,077,647. The Institute for Altitude Medicine (IFAM) contributions and grants were minimal in 2013 due to both the economy and a planned reduction in fundraising.

Total non-operating revenues for the 2013 calendar year ended at $3,555,668, compared to the non-operating revenues in 2012 of $3,346,078. Non-operating revenue is comprised of ad valorem taxes, contributions and

grants, interest income and other non-operating revenues. Contributions and grants are the biggest contributor to the variance in non-operating revenue and had a $244,358 increase from 2012. Ad valorem taxes decreased $33,067 in 2013 based on the decrease in assessed property values.

The major expenses incurred by the District during the 2013 calendar year were compensation and employee benefits of $3,317,196 and $649,495, respectively; information technology and professional services of $331,298; depreciation and amortization of $265,005, IT, equipment, and service contracts of $238,658, and materials and supplies of $236,872.

The District's net position at the end of the 2013 calendar year was $5,065,127 as compared to $4,789,857 at the end of the 2012 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 2013 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 health care coverage affect the District's collection of accounts receivable, cash flows, and results of operation. The provision for doubtful accounts for the 2013 calendar year was $106,969 and fully reserves all self-pay balances over 120 days old. The calendar year 2012 provision was $118,044.

3. Cash Flow Statements

The District's 2013 total cash used by operating activities was $1,421,443 as compared to $1,308,430 used in 2012. The increase of $104,013 is associated with staffing an additional provider and medical assistant during the peak times in order to meet increased demand, as well as the initial incentive payout as a part of the compensation plan, plus an increase in the cost of employee healthcare benefits. There was also a large increase in patient related grant activities which was included in both revenues and expenses.

Other sources of cash are primarily ad valorem taxes, but also consist of federal grant revenues. All federal grant monies were spent in the year received thus offset the revenues.

Capital uses of cash during 2013 were $209,899 and reflect an increase of $53,859 over the prior year. The 2013 purchases include a digital xray machine, server equipment upgrades, and the purchase of multiyear Microsoft office licenses. The 2012 capital use of cash was $156,040.

The 2013 increase in investing activities relates mostly to purchasing investments in Colotrust, a trust designed to offer Colorado local governments safe and liquid opportunities to diversify investments.

4. 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 a 2014 budget during the last quarter of the 2013 calendar year.

The original budget was updated and approved during the last quarter of the 2013 calendar year. The variance between the original and final budgets relate to operating and non-operating grant revenue and expenses that were received and spent after the original budget was approved.

The variance between the final budget and actual amounts are due to multiple revenue and expense items. Budgeted net patient service revenue was not realized offset by unanticipated non-operating grant revenues. Significant variances between the budgeted total compensation and benefits and the actual results relate to reduced patient services revenue as well as unanticipated grant reimbursement, the impact of salary deferment and utilization of non-benefitted staff. Other variances include planned projects and patient related grant expenses not incurred.

5. Economic and Other Factors

The days in accounts receivable ratio (DAR) at year end yielded 38 and 69 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 2012 was 36 and 68, 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 2013, the District filed insurance claims with 1,522 different insurance companies of which 48% were non-participating and represented 20% of the total patient revenue.

The day's cash on hand ratio at December 31, 2013 was 123 days versus day's cash on hand in December 2012 of 125 days. The decrease is linked to decrease in property values. 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	2013	2012	2011
Emergency Department	$ 73,382	$ 75,343	$ 105,111
Primary care Department	56,884	57,111	77,736
Total Charity Care	$ 130,266	$ 132,454	$ 182,847

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 2013 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, 2013 and 2012

	2013				2012
	THD *	IFAM **	TMCF ***	Total	Total
ASSETS					
Current Assets					
Cash and cash equivalents	$ 2,004,559	$ 30,403	$ 341,842	$ 2,376,804	$ 2,563,063
Investments	500,466	-	-	500,466	-
Accounts receivable from patient services & pledges, net of estimated uncollectibles of $297,886 (2013) and $282,662 (2012)	497,849	44	61,134	559,027	502,503
Other receivables	12,026	-	-	12,026	32,153
Ad valorem taxes receivable	1,537,313	-	-	1,537,313	1,821,878
Due from affiliates	20,656	-	-	20,656	132,227
Inventory	104,038	-	-	104,038	95,154
Other current assets	67,530	-	-	67,530	65,605
Total Current Assets	4,744,437	30,447	402,976	5,177,860	5,212,583
Capital Assets, net	2,216,438	19,527	-	2,235,965	2,291,071
Other Assets	53,450	-	-	53,450	33,595
Total Assets	7,014,325	49,974	402,976	7,467,275	7,537,249
LIABILITIES					
Current Liabilities					
Accounts payable	103,678	47	48,511	152,236	120,656
Due to affiliates	-	-	20,656	20,656	132,227
Accrued compensation and employee benefits	591,373	-	-	591,373	566,550
Other accrued liabilities	96,838	-	-	96,838	102,489
Unearned revenue	8,588	-	-	8,588	-
Total Current Liabilities	800,477	47	69,167	869,691	921,922
Total Liabilities	800,477	47	69,167	869,691	921,922
DEFERRED INFLOWS OF RESOURCES					
Imposed nonexchange revenue - ad valorem taxes	1,532,457	-	-	1,532,457	1,825,470
Total Deferred Inflows of Resources	1,532,457	-	-	1,532,457	1,825,470
NET POSITION					
Invested in capital assets, net of related debt	2,216,438	19,527	-	2,235,965	2,291,071
Unrestricted components of net position					
Unrestricted	1,839,953	29,413	330,138	2,199,504	2,114,405
Board designated	500,000	-	-	500,000	250,000
Temporarily restricted components of net position	125,000	987	3,671	129,658	134,381
Total Net Position	$ 4,681,391	$ 49,927	$ 333,809	$ 5,065,127	$ 4,789,857

* Telluride Hospital District - See Note 1

** Institute for Altitude Medicine - See Note 1 and Note 14

*** Telluride Medical Center Foundation - See Note 1 and Note 15

See accompanying notes.

TELLURIDE HOSPITAL DISTRICT

STATEMENTS OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION

For the years ended December 31, 2013 and 2012

	2013				2012
	THD	IFAM	TMCF	Total	Total
Operating Revenues					
Net patient service revenue	$ 3,796,617	$ 24,220	$ -	$ 3,820,837	$ 3,777,314
Contribution and donation income - Note 1 and 15	-	-	281,857	281,857	302,050
Other revenue	54,560	40	-	54,600	59,917
Patient related grant revenue	205,080	-	-	205,080	88,083
Total Operating Revenues	4,056,257	24,260	281,857	4,362,374	4,227,364
Operating Expenses					
Compensation	3,189,494	14,411	113,291	3,317,196	3,382,651
Contract services	151,862	2,815	-	154,677	76,941
Employee benefits	644,283	5,212	-	649,495	642,121
Program expenses	-	-	139,641	139,641	110,176
Information technology and professional services	325,696	1,352	4,250	331,298	343,444
Other operating expenses	232,102	2,301	11,479	245,882	241,175
Materials and supplies	235,079	1,557	236	236,872	242,006
Depreciation and amortization	260,212	4,793	-	265,005	242,814
IT, equipment, and service contracts	227,856	10,802	-	238,658	247,788
Patient related grant expense	189,057	-	-	189,057	56,235
Building and facilities	120,569	2,590	-	123,159	125,409
Utilities and support services	67,726	-	1,745	69,471	66,376
Insurance	88,831	525	1,175	90,531	76,943
Travel and entertainment	-	55	602	657	3,791
Research and development	-	343	-	343	405
Interest and loan fees	10	-	-	10	22
Total Operating Expenses	5,732,777	46,756	272,419	6,051,952	5,858,297
Income (Loss) From Operations	(1,676,520)	(22,496)	9,438	(1,689,578)	(1,630,933)
Non-operating Revenues					
Ad valorem taxes	1,873,101	-	-	1,873,101	1,906,168
Contributions and grants	271,787	40,109	1,292,719	1,604,615	1,360,257
Interest income	8,161	-	373	8,534	11,554
Other non-operating revenues	69,418	-	-	69,418	68,099
Total Non-operating Revenues	2,222,467	40,109	1,293,092	3,555,668	3,346,078
Non-operating Expenses					
Contributions and grants	92,297	-	1,292,719	1,385,016	1,177,308
Distribution to TMCF	187,667	-	-	187,667	195,035
Distribution to IFAM	2,400	-	-	2,400	5,479
Lhotka Conference	-	15,737	-	15,737	-
Total Non-operating Expenses	282,364	15,737	1,292,719	1,590,820	1,377,822
Total Non-operating Revenues, net	1,940,103	24,372	373	1,964,848	1,968,256
Increase in Net Position	263,583	1,876	9,811	275,270	337,323
Net Position - beginning of the year	4,417,808	48,051	323,998	4,789,857	4,452,534
Net Position - end of the year	$ 4,681,391	$ 49,927	$ 333,809	$ 5,065,127	$ 4,789,857

See accompanying notes.

TELLURIDE HOSPITAL DISTRICT

STATEMENTS OF CASH FLOWS

For the years ended December 31, 2013 and 2012

	2013				2012
	THD	IFAM	TMCF	Total	Total
Cash Flows From Operating Activities					
Cash received from patients and third-party payors	$ 3,754,959	$ 25,107	$ -	$ 3,780,066	$ 3,746,143
Cash received from other operating activities	279,767	40	266,100	545,907	312,836
Cash paid to suppliers and others	(1,495,322)	(19,478)	(240,363)	(1,755,163)	(1,549,412)
Cash paid to employees for services	(3,960,815)	(22,438)	-	(3,983,253)	(3,817,997)
Net Cash Provided (Used) by Operating Activities	(1,421,411)	(16,769)	25,737	(1,412,443)	(1,308,430)
Cash Flows From Non-capital Financing Activities					
Ad valorem taxes - Telluride Hospital District	1,864,653	-	-	1,864,653	1,913,449
Change in due to/from affiliate, net	110,892	-	(110,892)	-	373
Non-operating revenues	341,205	40,109	1,154,717	1,536,031	1,295,559
Non-operating expenses	(282,364)	(15,733)	(1,154,717)	(1,452,814)	(1,245,025)
Net Cash Provided (Used) by Non-capital Financing Activities	2,034,386	24,376	(110,892)	1,947,870	1,964,356
Cash Flows From Capital and Related Financing Activities					
Acquisition of property and equipment	(209,899)	-	-	(209,899)	(156,040)
Net Cash Used for Capital and Related Financing Activities	(209,899)	-	-	(209,899)	(156,040)
Cash Flows From Investing Activities					
Purchase of investments	(500,466)	-	-	(500,466)	-
Interest income received	8,161	-	373	8,534	11,554
Investment in HealthCare Management, Inc.	(19,855)	-	-	(19,855)	(33,595)
Net Cash Provided (Used) by Investing Activities	(512,160)	-	373	(511,787)	(22,041)
Increase (Decrease) in Cash and Cash Equivalents	(109,084)	7,607	(84,782)	(186,259)	477,845
Cash and Cash Equivalents - beginning of the year	2,113,643	22,796	426,624	2,563,063	2,085,218
Cash and Cash Equivalents - end of the year	$ 2,004,559	$ 30,403	$ 341,842	$ 2,376,804	$ 2,563,063

See accompanying notes.

TELLURIDE HOSPITAL DISTRICT

STATEMENTS OF CASH FLOWS

For the years ended December 31, 2013 and 2012

	2013				2012
	THD	IFAM	TMCF	Total	Total
Reconciliation of Operating Income (Loss) to Net Cash Provided (Used) by Operating Activities:					
Income (loss) from operations	$ (1,676,520)	$ (22,496)	$ 9,438	$ (1,689,578)	$ (1,630,933)
Adjustments to reconcile operating loss to net cash used for operating activities:					
Bad debts	201,472	80	-	201,552	206,969
Provision for contractual adjustments	1,605,678	8,188	-	1,613,866	1,543,629
Depreciation and amortization	260,212	4,793	-	265,005	242,814
Changes in:					
Accounts receivable from patient services & pledges	(1,848,808)	(7,381)	(15,757)	(1,871,946)	(1,783,163)
Other receivables	20,127	-	-	20,127	(21,803)
Inventory	(8,884)	-	-	(8,884)	(8,778)
Other current assets	(1,925)	-	-	(1,925)	(24,094)
Accounts payable and accrued liabilities	27,237	47	32,056	59,340	166,929
Net Cash Provided (Used) by Operating Activities	$ (1,421,411)	$ (16,769)	$ 25,737	$ (1,412,443)	$ (1,308,430)

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 14). Additional financial information pertaining to the TMCF may be obtained from Telluride Medical Center Foundation, P.O. Box 1229, Telluride, CO, 81435 (see Note 15).

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.

The District elected to early implement GASB No. 65, *Items Previously Reported as Assets and Liabilities*, for the year ended December 31, 2012. GASB No. 65 defines which items previously reported as assets and liabilities are now required to be reported as either deferred outflows or deferred inflows of resources. Under this statement, the District is reporting $1,532,457 (2013) and $1,825,470 (2012) of ad valorem taxes as deferred inflows of resources. The District did not have any deferred outflows of resources as of December 31, 2013 and 2012.

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 13 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 (the Board) has designated assets required to meet capital expenditures. These designated assets are included in cash and cash equivalents. At December 31, total Board designated assets to be used in the future purchase of land and a new facility was $500,000 (2013) and $250,000 (2012).

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, 2013 and 2012, 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 2013 and 2012 are reportable as a receivable and a deferred inflow 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. The District defines capital assets as assets with an initial cost of more than $10,000. 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:

Invested in capital assets, net of related debt - 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 - 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 - 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 revenues 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.

Advertising - Advertising costs are charged to operations when incurred. For the years ended December 31, 2013 and 2012, advertising expenses were $15,353 and $11,199, respectively.

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. With few exceptions, as of December 31, 2013, 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 2012 financial statements to conform to the 2013 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. The Board's 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 $6,475,888 and the final budgeted expenditures were $6,334,494 for the year ended December 31, 2013. The District expended less than was appropriated during 2013.

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, 2013:

	Actual	Budget	Variance - Favorable (Unfavorable)
Revenue:			
GAAP-based revenue	$ 4,056,257	$ 4,082,190	$ (25,933)
GAAP-based non-operating revenue	2,222,467	2,199,602	22,865
Total Budgetary Revenue	$ 6,278,724	$ 6,281,792	$ (3,068)
Expenses:			
GAAP-based expenses	$ 5,732,777	$ 5,883,049	$ 150,272
GAAP-based non-operating expenses	282,364	239,261	(43,103)
Adjustments:			
Capital outlay	209,899	212,184	506
Total Budgetary Expenses	$ 6,225,040	$ 6,334,494	$ 109,454

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:

	2013	2012
Insured (FDIC) or collateralized with securities held by the District	$ 548,743	$ 599,456
Collateralized by securities held by the pledging financial institution in accordance with PDPA	1,761,750	2,025,036
Total	$ 2,310,493	$ 2,624,492
Carrying Value	$ 2,376,804	$ 2,563,063

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

A concentration 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 99% of its cash deposits in one financial institution and 1% in a second institution.

NOTE 5 - INVESTMENTS

As of December 31, 2013, the District had $500,466 invested in Colotrust, a local government investment pool established for local governments in Colorado to pool surplus funds. These pools operate similarly to a money market fund and each share is equal in value to $1. Investments in Colotrust consist of U.S. Treasury and agency securities, the highest rated commercial paper and repurchase agreements collateralized by U.S. Treasury and agency securities and is rated AAAm by Standard and Poor's.

Custodial Credit Risk - Investments

Custodial credit risk for investments is the risk that in the event of failure of the counter party to a transaction, the District would not be able to recover the value of its investments or collateral securities that are in the possession of an outside party. The District's investments 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.

NOTE 6 - CAPITAL ASSETS

Capital asset activities for the years ended December 31 were as follows:

	2013			
	Beginning Balance	Additions	Deletions	Ending Balance
Building improvements	$ 2,475,302	$ 5,407	$ -	$ 2,480,709
Medical equipment	1,194,348	125,281	-	1,319,629
Furniture and fixtures	65,614	-	-	65,614
Administrative equipment	248,893	76,684	-	325,577
Construction in process	-	2,527	-	2,527
Total Cost	3,984,157	209,899	-	4,194,056

Less accumulated depreciation and amortization:				
Building improvements	642,439	88,855	-	731,294
Medical equipment	811,769	136,165	-	947,934
Furniture and fixtures	60,895	2,394	-	63,289
Administrative equipment	177,983	37,591	-	215,574
Total Accumulated Depreciation and Amortization	1,693,086	265,005	-	1,958,091
Capital assets, net	$ 2,291,071	$ (55,106)	$ -	$ 2,235,965

2012

	Beginning Balance	Additions	Deletions	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	7,486	248,893
Total Cost	3,851,228	156,040	23,111	3,984,157
Less accumulated depreciation and amortization:				
Building improvements	553,754	88,685	-	642,439
Medical equipment	702,798	124,596	15,625	811,769
Furniture and fixtures	58,501	2,394	-	60,895
Administrative equipment	158,330	27,139	7,486	177,983
Total Accumulated Depreciation and Amortization	1,473,383	242,814	23,111	1,693,086
Capital assets, net	$ 2,377,845	$ (86,774)	$ -	$ 2,291,071

NOTE 7 - INVESTMENT IN HEALTHCARE MANAGEMENT, INC.

The District invested in Healthcare Management, Inc. (HCM) during 2012. As of December 31, 2013 and 2012, the District had 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 8 - 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 $79,607 (2013) and $85,802 (2012) 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 $174,330 (2013) and $169,951 (2012).

NOTE 9 - 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, 2013 and 2012). This agreement has a maturity date of April 1, 2014. The line is collateralized by accounts receivable, inventory and equipment. As of December 31, 2013 and 2012, there were no draws on the line of credit.

NOTE 10 - 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, 2013:

THD	Invested in Capital Assets	Unrestricted	Unrestricted – Board Designated	Temporarily Restricted	Permanently Restricted	Total
Beginning net position	$ 2,266,751	$ 1,776,057	$ 250,000	$ 125,000	$ -	$ 4,417,808
Fixed asset additions	209,899	(209,899)	-	-	-	-
Transfers to board designated	-	(250.000)	250,000	-	-	-
Increases (decreases) in net position	(260,212)	523,795	-	-	-	263,583
Ending net position	$ 2,216,438	$ 1,839,953	$ 500,000	$ 125,000	$ -	$ 4,681,391

IFAM	Invested in Capital Assets	Unrestricted	Unrestricted – Board Designated	Temporarily Restricted	Permanently Restricted	Total
Beginning net position	$ 24,320	$ 22,400	$ -	$ 1,331	$ -	$ 48,051
Components of net position released from restriction	-	344	-	(344)	-	-
Increases (decreases) in net position	(4,793)	6,669	-	-	-	1,876
Ending net position	$ 19,527	$ 29,413	$ -	$ 987	$ -	$ 49,927

TMCF	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Beginning net position	$ 315,948	$ 8,050	$ -	$ 323,998
Components of net position released from restriction	4,800	(4,800)	-	-
Increases in net position	9,390	421	-	9,811
Ending net position	$ 330,138	$ 3,671	$ -	$ 333,809

NOTE 11 - 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 $3,900 (2013) and $2,925 (2012). Future minimum lease payments for the years ending December 31 are as follows:

2014	$ 3,900
2015	3,900
2016	3,900
2017	975
	$ 12,675

NOTE 12 - 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:

	2013	2012
Other third-party payors	57.8%	53.6%
Patient self-pay	33.0%	37.3%
Medicare	4.8%	5.2%
Medicaid	4.4%	3.9%

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

	2013	2012
Patient service revenue		
Emergency care	$ 2,963,898	$ 2,981,827
Community clinic	2,770,135	2,634,598
IFAM	32,488	43,941
Gross Patient Service Revenue	5,766,521	5,660,366
Financial hardship	(130,266)	(132,454)
Gross Patient Service Revenue, Net of Financial Hardship	5,636,255	5,527,912
Contractual adjustments	(1,613,866)	(1,543,629)
Provision for bad debts	(201,552)	(206,969)
Net Patient Service Revenue	$ 3,820,837	$ 3,777,314

NOTE 13 - 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, 2013 and 2012, 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, 2013 and 2012.

NOTE 14 - 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, 2013 and 2012 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 net position because asset title remains with the District. IFAM has reported contribution revenue and program expense amounting to $2,400 and $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, 2013 and 2012, respectively.

NOTE 15 - 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 $20,656 (2013) and $131,548 (2012).

As of December 31, TMCF had $281,857 (2013) and $302,050 (2012) of contribution and donation income, of which $102,768 (2013) and $104,389 (2012) 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 related to the PEP grant was $629,145 (2013) and $488,307 (2012). TMCF also received $138,002 (2013) and $132,797 (2012) in in-kind donations related to the PEP grant. Of that in-kind, $84,899 (2013) and $90,646 (2012) was support from the District. For the years ended December 31, 2013 and 2012, all monies were spent in the year received.

TMCF was awarded three grants under CFDA#93.912, Rural Health Care Services Outreach, Rural Health Network Development and Small Health Care Provider Quality Improvement Program. The objective of which is to expand delivery of health care services in rural areas, for the planning and implementation of integrated health care networks in rural areas, and for planning and implementation of small health care provider quality improvement activities. The first program awarded was the Small Health Care Provider Quality Improvement Program which supports rural public, rural non-profit, or other providers of healthcare services, such as a critical access hospital or rural health clinic. The second and third programs awarded were the Rural Health Information Network Program and the Rural Health Care Services Outreach Program which both support the delivery of health care services. Revenue for 2013 and 2012 related to the three grants was $525,572 and $456,543, respectively. For the years ended December 31, 2013 and 2012, all monies were spent in the year received.

NOTE 16 - 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, 2013 and 2012 were $214,948 and $207,045, respectively.

NOTE 17 - SUBSEQUENT EVENTS

The District has evaluated subsequent events through April 28, 2014, the date at which the financial statements were available to be issued, and determined that no events have occurred that required disclosure.

REQUIRED 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, 2013

	Budgeted Amounts			Favorable (Unfavorable)
	Original	Final	THD Actual	Variance
Operating Revenues				
Net patient service revenue	$ 3,901,796	$ 3,823,492	$ 3,796,617	$ (26,875)
Other revenue	48,234	53,245	54,560	1,315
Patient related grant revenue	-	205,453	205,080	(373)
Total Operating Revenues	3,950,030	4,082,190	4,056,257	(25,933)
Non-operating Revenues				
Ad valorem taxes	1,861,068	1,867,639	1,873,101	5,462
Contributions and grants	212,252	259,805	271,787	11,982
Interest income	10,500	8,743	8,161	(582)
Other non-operating revenues	56,900	63,415	69,418	6,003
Total Non-operating Revenues	2,140,720	2,199,602	2,222,467	22,865
Total Budgetary Revenues, net	$ 6,090,750	$ 6,281,792	$ 6,278,724	$ (3,068)
Operating Expenses				
Compensation	$ 3,370,072	$ 3,265,905	$ 3,189,494	$ 76,411
Contract services	6,942	147,285	151,862	(4,577)
Employee benefits	718,448	677,666	644,283	33,383
Professional and consulting fees	377,163	327,311	325,696	1,615
Other operating expenses	244,083	238,664	232,102	6,562
Materials and supplies	261,016	237,286	235,079	2,207
Depreciation and amortization	241,835	259,890	260,212	(322)
IT, equipment, and service contracts	248,596	244,068	227,856	16,212
Patient related grant expense	-	206,524	189,057	17,467
Building and facilities	116,950	116,950	120,569	(3,619)
Utilities and support services	80,913	64,898	67,726	(2,828)
Insurance	95,617	96,590	88,831	7,759
Interest and loan fees	-	12	10	2
Total Operating Expenses	5,761,635	5,883,049	5,732,777	150,272
Non-operating Expenses				
Contributions and grants	211,368	131,861	92,297	39,564
Distribution to TMCF	102,345	105,000	187,667	(82,667)
Distribution to IFAM	2,400	2,400	2,400	-
Total Non-operating Expenses	316,113	239,261	282,364	(43,103)
Capital Outlay	398,140	212,184	209,899	2,285
Total Budgetary Expenses	$ 6,475,888	$ 6,334,494	$ 6,225,040	$ 109,454

See independent auditor's report.

OTHER SUPPLEMENTAL INFORMATION

TELLURIDE HOSPITAL DISTRICT

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

For the year ended December 31, 2013

	Emergency Care	Primary Care	THD Total
Operating Revenues			
Net patient service revenue	$ 2,080,968	$ 1,715,649	$ 3,796,617
Other revenue	-	54,560	54,560
Patient related grant revenue	-	205,080	205,080
Total Operating Revenues	2,080,968	1,975,289	4,056,257
Operating Expenses			
Compensation	2,102,314	1,087,180	3,189,494
Contract services	142,825	9,037	151,862
Employee benefits	435,543	208,740	644,283
Professional and consulting fees	194,484	131,212	325,696
Other operating expenses	164,288	67,814	232,102
Materials and supplies	107,902	127,177	235,079
Depreciation and amortization	260,212	-	260,212
IT, equipment, and service contracts	208,703	19,153	227,856
Patient related grant expense	18,309	170,748	189,057
Building and facilities	117,274	3,295	120,569
Utilities and support services	64,585	3,141	67,726
Insurance	72,722	16,109	88,831
Interest and loan fees	2	8	10
Total Operating Expenses	3,889,163	1,843,614	5,732,777
Income (Loss) from Operations	(1,808,195)	131,675	(1,676,520)
Non-operating Revenues			
Ad valorem taxes	1,816,218	56,883	1,873,101
Contributions and grants	122,026	149,761	271,787
Interest income	8,039	122	8,161
Other non-operating revenues	27,253	42,165	69,418
Total Non-operating Revenues	1,973,536	248,931	2,222,467
Non-operating Expenses			
Contributions and grants	8,884	83,413	92,297
Distribution to TMCF	102,768	84,899	187,667
Distribution to IFAM	2,400	-	2,400
Total Non-operating Expenses	114,052	168,312	282,364
Total Non-operating Revenues, net	1,859,484	80,619	1,940,103
Increase in Net Position	$ 51,289	$ 212,294	$ 263,583

See independent auditor's report.

EXHIBIT C – DWC RECOMMENDATION LETTER

DALBY, WENDLAND & CO., P.C.

Grand Junction

CPAs and Business Advisors

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

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, 2013, 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

April 28, 2014

EXHIBIT C – 2013 MDA

Telluride Hospital District

Audit Reporting Package

For the Year Ended December 31, 2013

Telluride Hospital District

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DALBY, WENDLAND & CO., P.C.

Grand Junction

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Board of Directors
Telluride Hospital District
Telluride, Colorado

We have audited the financial statements of Telluride Hospital District (the District) for the year ended December 31, 2013, and have issued our report thereon dated April 28, 2014. Professional standards require that we provide you with the information about our responsibilities under generally accepted auditing standards, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our engagement letter to you dated September 12, 2013. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Findings

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the District are described in Note 1 to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during 2013. We noted no transactions enter into by the District during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the financial statements were:

- Management's estimate of the patient receivables is reduced by a valuation allowance that reflects management's evaluation of amounts that will not be collected from patients and third-party payors. We evaluated the key factors and assumptions used to develop the carrying amount of the patient receivables in determining that it is reasonable in relation to the financial statements taken as a whole.
- Management's estimate of depreciation expense is based on management's evaluation of the useful lives of property and equipment. We evaluated the key factors and assumptions used to determine the useful lives in determining that it is reasonable in relation to the financial statements taken as a whole.

Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the financial statements were:

- The disclosure of budgets in Note 2 to the financial statements.
- The disclosure of concentrations of credit risk in Note 12 to the financial statements.
- The disclosure of contingencies in Note 13 to the financial statements.
- The disclosure of IFAM in Note 14 to the financial statements.
- The disclosure of the Telluride Medical Center Foundation in Note 15 to the financial statements.

Difficulties Encountered in Performing the Audit
We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements
Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. Refer to Appendix A for a summary of audit adjustments.

Disagreements with Management
For purposes of this letter, a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations
We have requested certain representations from management that are included in the management representation letter dated April 28, 2014.

Management Consultations with Other Independent Accountants
In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the District's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues
We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the District's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Other Matters
With respect to the supplementary information accompanying the financial statements, we made certain inquiries of management and evaluated the form, content, and methods of preparing the information to determine that the information complies with U.S. generally accepted accounting principles, the method of preparing it has not changed from the prior period, and the information is appropriate and complete in relation to our audit of the financial statements. We compared and reconciled the supplementary information to the underlying accounting records used to prepare the financial statements or to the financial statements themselves.

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

Sincerely,

Dalby, Wendland & Co., P.C.

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

April 28, 2014

Appendix A - Summary of Audit Adjustments

The following report details the resulting journal entries from the audit of the financial statements of Telluride Hospital District as of December 31, 2013 and for the year then ended.

Telluride Hospital District

Adjusting Journal Entries JE # 1

Provided by Client - To true up accumulated depreciation and depreciation expense at year end.

1891	Accum. Depr. Medical Equip	$	2,297		
1894	Accum Depr - Bldg & Improvement		742		
1892	Accum. Depr. Admin Equip			$	1,786
7100	Depreciation Expense				1,253
Total		**$**	**3,039**	**$**	**3,039**

Adjusting Journal Entries JE # 2

To adjust beginning retained earnings to match prior year issued financial statements.

6910	Other Admin Costs	$	49		
3110	Retained Earnings			$	49
Total		**$**	**49**	**$**	**49**

Adjusting Journal Entries JE # 3

To true up deferred inflows and mill levy receivable to actual and to reclassify deferred grant revenue for financial statement purposes.

2050	Deferred Revenue	$	50,827		
1270	Next Year Mill Levy Receivable			$	42,239
DWC - 2	Deferred Grant Revenue				8,588
Total		**$**	**50,827**	**$**	**50,827**

Adjusting Journal Entries JE # 4

DO NOT POST: To record in-kind support to TMCF related to the PEP grant.

9045	Support to Foundation	$	33,584		
6012	Grant Offsets, Administrative			$	2,940
6180	Grant Offsets-PEP & RHITND				1,394
8751	Rents - In Kind PEP				29,250
Total		**$**	**33,584**	**$**	**33,584**

Telluride Medicare Center Foundation

Adjusting Journal Entries JE # 5

DO NOT POST: To reclass the 10/21/13 PEP grant draw down to properly record 2013 revenue and expense.

5110	PEP Grant Equipment & Supplies	$	10,237		
4740	Carol M White Physical Educatio			$	10,237
Total		**$**	**10,237**	**$**	**10,237**

Appendix A - Summary of Audit Adjustments

Adjusting Journal Entries JE # 6			
To properly record the temporary restriciton of funds related to the ThinkHead First program.			
3200	Unrestricted Net Assets	$ 3,250	
3150	Temp. Restricted Net Assets		$ 3,250
Total		**$ 3,250**	**$ 3,250**

Adjusting Journal Entries JE # 7			
DO NOT POST: To record in-kind support received from TMC and others related to the PEP grant.			
5180	PEP In-Kind Exp All Supporters	$ 43,266	
4750	PEP In-Kind Contributions-TMC		$ 33,584
4752	PEP In-Kind Support All Others		9,682
Total		**$ 43,266**	**$ 43,266**

Adjusting Journal Entries JE # 8			
To record PEP grant payable and receivable at year end.			
1105	Accounts Receivable	$ 7,455	
5110	PEP Grant Equipment & Supplies	7,455	
2000	Accounts Payable		$ 7,455
4740	Carol M White Physical Educatio		7,455
Total		**$ 14,910**	**$ 14,910**

Institute for Altitude Medicine

Adjusting Journal Entries JE # 9			
To adjust beginning retained earnings to match prior year issued financial statements.			
6910	Other Admin Costs	$ 102	
3110	Retained Earnings		$ 102
Total		**$ 102**	**$ 102**

Adjusting Journal Entries JE # 10			
DO NOT POST: To record in-kind contribution from Telluride Hospital District for rent expense.			
6760	Rent	$ 2,400	
8102	THD Monthly In-Kind Contrib		$ 2,400
Total		**$ 2,400**	**$ 2,400**

Adjusting Journal Entries JE # 11			
Client Requested - To record depreciation expense for the current year.			
7100	Depreciation Expenses	$ 4,793	
1891	Accum Depr Medical Equipment		$ 4,195
1894	Accum Depr - Bldg & Improv		598
Total		**$ 4,793**	**$ 4,793**

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

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, 2013, 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

April 28, 2014

Exhibit D – 2014 Annual Operating Budget
Income Statement - Actual vs. Prior Year
January through December 2014

	Estimated Jan - Dec 14	Actua Jan - Dec 13
Ordinary Income/Expense		
Income		
4000 · Patient Revenue	6,741,647.53	5,603,767.07
4100 · Revenue Deductions	(2,532,899.67)	(1,807,150.00)
4300 · Other Operating Income	267,254.25	259,639.23
Total Income	4,476,002.11	4,056,256.30
Cost of Goods Sold		
5400 · Materials and Other	336,391.38	260,136.88
5000 · TMC Contract Physicians	47,682.02	151,861.52
5001 · Employed Physician Services	1,433,952.92	1,231,820.00
5100 · Clinical Services Cost	1,856,641.66	1,826,423.77
Total COGS	3,674,667.98	3,470,242.17
Gross Profit	801,334.13	586,014.13
Expense		
6800 · Utilities	75,569.18	67,726.37
6000 · Administrative Wages & Salaries	767,833.39	769,799.63
6100 · Employee Benefits	248,598.01	194,787.29
6300 · Professional & MIS Fees	330,158.48	300,637.82
6500 · Building & Facilities	120,947.38	120,569.03
6600 · Equip Leases, Svc Contracts, IT	227,673.75	227,857.08
6700 · Property Tax & Rents	27,600.00	23,784.00
6750 · Insurance	93,748.51	88,831.44
6900 · Other Operating Expenses	159,196.45	153,778.44
7000 · Non-Cash Expenses	237,263.58	260,212.28
Total Expense	2,288,588.73	2,207,983.38
Net Ordinary Income	(1,487,254.60)	(1,621,969.25)
Other Income/Expense		
Other Income		
8000 · Mill Levy Income	1,552,317.36	1,818,611.26
8100 · Grant Income	179,033.64	271,241.44
8200 · Contribution Income		546.25
8500 · Other Income	66,372.07	136,079.16
Total Other Income	1,797,723.07	2,226,478.11
Other Expense		
6990 · Grant Expenses	72,808.83	150,796.68
8450 · TMC Foundation Activity		
9000 · Other Expenses	103,140.00	190,076.94
Total Other Expense	175,948.83	340,873.62
Net Other Income	1,621,774.24	1,885,604.49

Exhibit D – 2014 Annual Operating Budget

Income Statement - Actual vs. Prior Year

January through December 2014 Actua

	Jan - Dec 14	Jan - Dec 13
Net Income	**134,519.64**	**263,635.24**

Exhibit E – Mill Levy Actual Projected

Telluride Hospital District
Mill Levy broken out by purpose

	2015	2014	2013	2012	2011
Mill Levy - General Operations	$671,652	$671,180	$ 794,449	$ 827,182	$ 917,729
Mill Levy - 24HR Emergency Services	$859,714	$859,111	$ 1,016,895	$ 1,058,793	$ 1,174,525
Mill Levy - Abatements	$0	$5,158	$ 6,105	$ 20,199	$ 12,629
	$ 1,531,366	$ 1,535,449	$ 1,817,449	$ 1,906,174	$ 2,104,884

Exhibit F – Assessed Value Mill Levy History

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
2015	671,651,650	671,651,650	1.0	1.280	-	0
2014	670,366,350	670,366,350	1.0	1.280	0.006	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	764,580,460	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
2006	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 are not available.

Exhibit G – TMC Foundation Report
Kate Wadley, Executive Director

- **Telluride Medical Center Foundation:**
  1. 2014 was Major Gift annual campaign focused
  2. Interviewed Capital Campaign consultants/ Selected Community Counseling Service (CCS)
  3. 2014 End of year total $200,833 – Largest End-of-the-Year-Appeal yet
  4. Ongoing updating the Wall of Appreciation on the exterior entrance of the Emergency Department
  5. Successful Play for Pink Golf Tournament (purchased 50 reusable Sponsor Signs). The TMCF was the major benefactor.
  6. Band-Aids & BBQ was July 2, Newly located at the Elks and was deemed a success.
  7. Executive Director achieved Incentive Objectives for 2014
  8. The 2014 Year End Appeal funded Digital EKG, New Ultra Sound, Two new Heat Monitors and a new Mobile Vitals Monitor by raising over $120,000

- **Foundation Database:**
  1. Grew the Foundation mailing list in e-Tapestry database – An additional 233 contacts were added (first time Donors and new home sales)

- **2015 Goals:**
  1. Complete the Feasibility Study for Fundraising potential with CCS
  2. Identify and cultivate major donors to contribute to the new Medical Center
  3. The major equipment giving opportunity for 2015 is TBD.
     (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)
  4. Communications Newsletter and Hire a professional PR firm
  5. Work in a defined relationship with the Telluride Foundation
  6. In 2014 the TMCF will recruit new board members and develop a Fundraising Committee to assist with a Capital Campaign for a new facility
  7. The Foundation will detail a road map for Major Gifts in 2015. They will develop a top 100 prospects and top 100 pipeline list
  8. Achieve Incentive Objectives for 2015
  9. Develop a Capital Campaign Strategy
  10. Secured Play for Pink for August 4, 2015 and will again be the major benefactor

Exhibit H – Emergency Department Annual Report
Trauma and Emergency Services 1/2014-12/2014 Report
Melissa Tuohy, ED Nurse Manager

ED Volume as of December 31, 2014: 3497 patients, Increased 9%compared to previous year.
ED Total Charges as of December 31, 2014: Increase of 19% compared to previous year.

Dr. Diana Koelliker remains the Medical Director of Trauma and Emergency Services.

Policy and Procedures:

Policy and Procedures were reviewed. We added a new policy for Restraints. We developed a Quick Reference Sheet for Ventilator Operation/Settings. We created a Rapid Sequence Intubation Box that keeps essential intubation medications at our fingertips with rapid access. A Transient Internal ED Diversion to FP Policy was developed to improve patient flow during high ED volume/acuity times. A formal Trauma Team Activation (TTA) form was developed to better track those patients meeting TTA criteria. Those statistics are reported monthly in QA meeting minutes.

Affiliation with St Mary's:

SMH continues to supply blood to the ED. We have used it once this year.

New Equipment:

We received a new EKG machine and U/S machine this year.

Staff Education:

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

The ED arranged several mandatory meetings for all staff to discuss TMC's preparedness for screening/evaluating/treating a suspected Ebola patient. Gary Freedman from the Telluride Fire District HAZMAT department provided a hands-on training for donning and doffing protective equipment when caring for a highly infectious patient. We updated our equipment/inventory and stocked training gear to have semi-annual trainings.

The ED held its annual training for equipment/policy review. Items covered were ventilator use/set-up, Lifepak 12 use/set-up, blood administration P/P, restraint use/order sheet, Panda Baby warmer bed, new RSI kit/paperwork. All ED staff attended.

General ED Updates:

TMC Trauma Program underwent its Level V Review in April 2014. We were re-designated for three years as a Level V Trauma Center.

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.

Quality Assurance:

See separate QA report for details. Three quality initiatives were tracked this year, which included documenting patient weights in kilograms, circulation, motor, and sensation documentation on patients on arrival and after splinting, IV fluid completely documented.

Annual ED QA Report January 2014 to December 2014

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.
2. The ED has monthly QA meetings except for bi-monthly meetings during the off-season. 58 Trauma cases were reviewed. 119 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. RNs were reminded to have thorough vital sign documentation.
    c. TTAs were tracked to ensure appropriate staffing and response times by EMS and ED staff.
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.

Exhibit I – 2014 Primary Care/Community Clinic Report
Eric Johnson, NP Practice Manager

Primary Care had another banner year.
PC Volume as of 12/28/14: 15,119 up 12 % from previous year .weeks.
PC Charges as of 12/28/14: 3,394,485 Up 23% over last year.

Policy and Procedures:

All policies and procedure were reviewed with no change to existing.

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 fourth year. This has proved invaluable in enabling us to achieve Meaningful Use for the fourth year. These conferences have also helped us to more fully and efficiently use eCW to improve patient care. We upgraded too eCW version 10 in the spring of 2014. This upgrade facilitated continued participation in the Comprehensive Primary Care Initiative (CPCI) and reporting on Meaningful Use 2 in 2014 and ultimately to work towards certification as a Level III Patient Centered Medical Home (PCMH).

Meaningful Use:

PC attested for Meaningful Use at the end of 2011 through 2014. This resulted in additional payments to PC from CMS of $56,000. MU payment for 2013 was $15,680. Payments for 2014 are pending at the time of this report. 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 began in 2014 and Dr. Gaylord and Grundy have successfully attested and Dr. Linder has attested for Meaningful Use 1

General PC Updates:

This is PC's 36rd 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 2014, Dr Gaylord has been at TMC for 18 years, Eric Johnson, 17 years, Laura Cattell, 14 years and Dr. Grundy, 123 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, originally at 1 day a week, she is now working 3 days a week. Starting Jan 2015 Christine Tealdi PA-C has been hired part tame. She is working 2 days a week in PC and 1 day for the CPCI grant to provide care management services. 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. The need continues to grow and we are now staffing a fourth provider on Mon. and Tues. This has created a bit of a space crunch and has displaced visiting providers. In order to maintain this valuable service the conference room was remodeled to provide a flexible exam space.

TMC PC remains a Vaccine for Children (VFC) provider, annually passing its 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. With the implementation of eCW Version 10, that an interface between CIIS and eCW is now functional, but due to some technical issues is stil in testing stage. We anticipate full functionality in early 2015. This will eliminate double entry of immunizations. This has been a slow process industry wide, but we are hoping this will come to fruition early 2015

The past year saw continued success of TMC's most important community outreach program; May Health Month. The October Health Fair in 2014 was poorly attended and is not currently planned for 2015. The low attendance is likely due to the full implementation of the Affordable Care Act (ACA) in 2014, giving many morepeople access to health insurance and the preventative care services that insurance now provides at no cost to the patient. TMC will continue to offer discounted laboratory exams in October for those patients still without insurance. This is particularly helpful for those patients with chronic diseases. 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. There is no plan to resume these services in the future.

Quality Assurance/Quality Improvement

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 has left us as Care Coordinator to pursue a Nursing degree. Bridgett Taddiano has assumed 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 2014 Primary Care met and reported on all required CPCI milestones and has begun work on the 2015 milestones as well. PC's participation in this program has improved patient care and provided PC with significant additional revenue

Patient Centered Medical Home

PC had committed to pursuing certification as a PCMH in 2014. Due to the increased demands of the CPCI program, this was not feasible. This will be considered again in 2015

Respectfully,

Eric C. Johnson, MS, CFNP-BC

Exhibit J

Service Report for Radiology for 2014

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 as needed. 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 2013 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 has improved efficiency and lowered 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. This year we installed Erad PACS system and replaced all our viewing stations. The Erad PACS is internet based and can be accessed via any computer with internet access. Next year we will connect the Erad PACS to our EHR eclinicalworks and QHN so that we can access the images from within our EHR along with the report received from QHN. We have an IPAD in the ER which allows us to show patients their images bedside. Visiting specialist have log on access to the Erad PACS which enables them to access images off site.

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 the Erad PACS 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 was renewed this year from ACR for our CT scanner and expires in July 2017. 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 as needed 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 Erad PACS. A new ultrasound was purchased in late December. The Zonare Pro will replace the GE Logiq in January of 2015.

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 electronically sent back to Telluride Medical Center from QHN and this report attaches to the patient's medical record and routes to the ordering 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 ERad PACs system images can viewed anywhere that has an internet connection and a user log on. We can receive images from St. Mary's and Montrose Memorial hospitals.

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 gives our web enabled patients access to these reports via our web portal.

Supplies- Through our relationship with St. Mary's Hospital we are still part of Premier's GPO which helps to reduce our supply costs.

Procedures-

Please find an attached spreadsheet demonstrating number of procedures and revenue generated for Jan-Dec 2014.

Exhibit K – Pharmacy Report
Annual Pharmacy Summary 2014

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 Watenpaugh 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 Watenpaugh, R.Ph., consultant pharmacist monthly in 2014 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 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 08/13/2014. Minimal deficiencies were noted, no changes were needed. The CII Narcotic log was up to date, all paperwork was filed properly. Mark Watenpaugh R.Ph and I will coordinate times for regular monthly visits.

The Medical Staff met in July of 2014 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. Pam McCreedy and I noted that reimbursement for take home packages of medications was minimal, and that it would be more cost effective to dispense medications such as antibiotics by the each, and then have the patient fill the remainder at the local pharmacies. We have been slowly replacing these drugs as the 'homepacks' have been dispensed. This seems to be working well, and we charge a higher price point for most by the each medication.

Two new medications we acquired include Activase (tPA) and Curosurof (Surfactant). Our first dose of Activase was generously donated by a donor via the Telluride Medical Center 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). We used one dose in 2014. 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. 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.

Medication ordering continues to be an issue with availability, backordered items, discontinued drugs, minimum orders and price increases being the biggest issues. We remain contracted with Premier/Adventist, a PPO buying group in which we receive substantial discounts on pharmaceuticals. Our primary supplier is Cardinal Health Pharma hospital account. 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. Many drugs are no longer available in generic form and brand names cost significantly more. I am always trying to find the best price offered from our various suppliers. 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 these medications.

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 214 medications for use in the ED and Primary Care. Medications are ordered weekly and as needed 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. Betsy works with the formulary 30 minutes/week. Suppliers also require current licensure to be provided to them. A yearly inventory is performed for accounting purposes.

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

Exhibit L – 2014 Clinical Lab Report

Telluride Medical Center
Eric Johnson, NP

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 6/17/16.

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

There has been little significant change in the laboratory functions and equipment in the last year. The majority of the information below is continued to be included for historical perspective.

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 2014, the lab is successful in a majority of its testing. The last hematology event of 2014 did show a failure related to a single measure in the CBC. Corrective action has been initiated and protocols put in place to avoid repeat problems. No patient outcomes were affected. 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 – 2014 Medical Staff Report
Telluride Medical Center
Medical Staff Annual Report
Daniel Hehir, MD
Chief of Medical Staff

In 2014 the Medical Staff approved the credentialing of Dr.s Ziercher, Manning, Erwin, Yeowell and Dolbec all as locums doctors for the TMC Emergency Department. Dr. Cohen was approved as a visiting psychologist. Rae Shaffner was approved as a clinical social worker. Drs. Kettinger, Wong, Wall, and Levitt were credentialed as visiting residents.

2014 was an on year for our semiannual recredentialing process. Every provider in the facility was recredentialed in our extensive review process. A list of current providers listed by specialty is attached on the next page.

Dr. Hehir has been created privilege delineation descriptions for all of the provider specialties at TMC. These have been added to the credentialing process for all providers and provide an understanding between providers, management and the TMC board about what limits a provider has at on their practice at TMC.

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 the 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.

Upcoming projects will be a review of the medical staff bylaws especially in regards to credentialing requirements of some of our new providers including a clinical social worker and a psychologist.

Telluride Medical Center List of Providers

Emergency
Hehir
Kotlyar
D. Koelliker
P. Koelliker
Hackett
Ziercher
Erwin
Manning
Dolbec
Klein
Yeowell

Orthopedics
Singh
Bynum
Judkins
Biem
Leonard PA-C
Sandusky PA-c
Purnell
Griggs

Psychology
Cohen

Primary Care
Grundy
Gaylord
Johnson
Cattell
Linder
Tealdi

Midwifery
Grant
Ramirez

Opthalmology
Dahl

Psychiatry
Karls

Urology
Peterson

Clinical Social Work
Shaffner