Agenda

Estes Park Health Board of Directors' Regular Meeting - On Line Only

Monday, April 27, 2020

3:45 - 4:00 pm Public Open House - Cancelled - COVID-19 Social Distancing Implemented

4:00 - 6:00 pm Board Meeting

Estes Park Health, 555 Prospect Avenue, Estes Park CO 80517

Timberline Conference Room / https://attendee.gotowebinar.com/register/3115140408009461 90

3:45 - 4:00 pm Public Open House - Informational Conversations with Board Members - CANCELLED

	Regular Session	Mins.	Procedure	Presenter(s)
1	Call to Order/Welcome	1	**Action**	Dr. David Batey
2	Approval of the Agenda	1	**Action**	Board
3	Public Comments on Items Not on the Agenda and Farewell Comments for Chief Nursing Officer Ms. Terri Brandt Correia		Information	Public
4	General Board Member Comments and Farewell Comments for Chief Nursing Officer Ms. Terri Brandt Correia	10	Information	Board
5	Consent Agenda Items Acceptance: 5.1 Board Minutes 5.1.1 Regular Board Meeting Minutes March 30, 2020 5.1.2 Special Board Meeting Minutes April 15, 2020 5.1.3 Special Board Meeting Minutes April 17, 2020 5.2 Reports 5.2.1 Home Health/Hospice Program Quarterly Report	2	**Action**	Board Ms. Sarah Bosko
6	Presentations:			
	6.1 May 5, 2020 Estes Park Health Board Election Update	5	Discussion	Ms. Sarah Sheppard
	6.2 Resoulution 2020-05: Approval of SBA Loan from Payroll Protection Program as Support for COVID-19 Expenses	5	Information	Mr. Tim Cashman
	6.3 Audited End of Year 2019 Financials	20	Discussion and **Action**	Mr. James Mann
	6.4 COVID-19 Preparation and Status Update	25	Discussion	Mr. Gary Hall, Ms. Terri Brandt Correia, Dr. John Meyer
	6.5 CEO Report	15	Discussion	Mr. Vern Carda
	6.6 Community Paramedics Program Update	10	Discussion	Mr. Guy Beesley
	6.7 Urgent Care Center Status Update	5	Discussion	Ms. Barbara Valente
	6.8 Alarado Outpatient Clinic Status Update	5	Discussion	Mr. Tim Cashman
	6.9 1Q2020 Financials	10	Discussion	Mr. Tim Cashman
	6.10 COVID-19 Possible Financial Impacts on Estes Park Health	10	Discussion	Mr. Tim Cashman
7	Operations Significant Developments: *Goals, Accomplished, Next Actions, Schedule, Issues* 7.1 Executive Summary - Significant Items Not Otherwise Covered	3	Discussion	Senior Leadership Team
8	Medical Staff Credentialing Report	2	**Action**	Board
9	Review any Action List Items and Due Dates	1	Discussion	Board
10	Potential Agenda Items for May 18, 2020 Regular Board Meeting	2	Discussion	Board
11	Adjourn - April 27, 2020 Regular Board Meeting	1	**Action**	Dr. David Batey
	Total Regular Session Mins.	133		

Next Regular Board Meeting: Monday, May 18, 2020 4:00 - 6:00 pm

ESTES PARK HEALTH
BOARD OF DIRECTORS'
Regular Meeting Minutes – March 30, 2020
Virtual Meeting

Board Members in Attendance via Virtual
Dr. David Batey, Chair; Ms. Sandy Begley, Vice-Chair; Dr. Monty Miller, Treasurer; Ms. Diane Muno, Secretary; Mr. William Pinkham, Member-at-Large.

Other Attendees via Virtual
Mr. Vern Carda, CEO, Mr. Tim Cashman, CFO; Mr. Gary Hall, CIO; Ms. Terri Brandt Correia, CNO; community and staff members.

Community Attendees: Aaron Alberter, Dwight Stanford, Debby Hughes, James Whiteneck, Jessica Jenkins, John Cooper, Jim and Gail Cozette, Johanna Darden, the Moennings, Susan Wolf, Sandy Chockla, Tim Mosier, Drew Webb, Ericka Santana, Morgan Svoboda, Robert Foster, Larry Leaming, Bill Solms

Call to Order
The Board Open Session was Called to Order at 4:09 p.m. by Dr. Batey, Chairman of the Board of Directors; there was a quorum present. Notice of the Board Meeting was posted in accordance with the SUNSHINE Law Regulation. First Virtual Regular Board Meeting

Approval of 03/30/20 Meeting Agenda

A motion was made by Bill Pinkham to approve the 03/30/20 meeting agenda as submitted, the motion was seconded by Monty Miller. A verbal vote was requested – the ayes were unanimous, and the motion was carried.

Public Comments
- There was no public sign-in sheet since the meeting was virtual – No comments were submitted through the chat function to Gary Hall. (Happy Doctor's Day)
- Sign in sheet can be requested through the Administration office at Estes Park Health.

Welcome EPH CEO Vern Carda and Board Member General Comments
Vern: Wonderful to be here and I appreciate the opportunity to serve. One question placed was why would Vern be interested? Answer: I like challenge, these are challenging times and I look forward to serving.
Diane: Thank Vern and welcome attendees.
Bill: Delighted to have Vern on Board and look forward to working with him.

Consent Agenda Items - ***Attachment 1***
- Board Study Session – 03.11 2020 – COVID-19 Preparedness
- Board Meeting Minutes 02.24.2020
- May 2020 Board Election
- COVID-19 Preparation and Status Update
- Colorado End-of-Life Options Act Review
- Estes Park Health Foundation
- Chief of Staff Update

- 4th Q and End of Year Financials
- Financing the Alarado Tenant Improvements and Facility Master Plan

All reports are available upon request through the Administration office at Estes Park Health.

A motion was made by Bill Pinkham to accept the Consent Agenda items listed above; the motion was seconded by Monty Miller. A verbal vote was requested – the ayes were unanimous, and the motion was carried.

Presentations

- **May 2020 Estes Park Health Board Election** – Sarah Shepherd gave overview. Sarah provided a memo outlining the progress of election. UOCAVA ballots have been mailed. Election publication will be released in April. Sarah is working with Randy Brigham to work through logistics. Drop box located in Estes Park Health. 1 standard stamp to mail them back. Diane: Concerned about having the box in the door. Encourage everyone to mail in their ballot. Many concerns about the safety of having people come to the door. Look at plan and perhaps have different location. Wants an election with high turn out, so we want the best plan. We won't compromise patient or staff safety. Board has an action to review ballot box.

- COVID-19 Preparation and Status Update: Gary is leading the discussion. Established a 24/7 Operations Committee in Command Center. Daily 8:30 a.m. huddle to discuss all needs and work the issues. Feel very good about proactivity. When surge gets here, we want to be prepared. Community can call the COVID-19 Ops and Triage hotlines. Continue to get messaging out to be screened, screened at a distance. Work with all healthcare and governmental partners to make sure we're all on board with resources and needed changes. Immense expertise put into surge plan. Know how to act at each of the different levels. We must give high credence to the health of our small staff. We must protect them. Hoping to minimize the surge. It is a daily and hourly effort; we know our resources and want to optimize all resources. Terri – we have a highly engaged medical staff. Erica – we've been two steps ahead of other local agencies. David – gave out phone numbers. Monty – any resources we need. Gary responded that we are working with cache and others in the community to make sure we have supplies. Terri – for a critical access we are ahead of many others and well prepared. Diane – wants to appreciate the work being done. She was impressed with the level of detail of everyone engaged. Do we have tests and how many? Do we have PPE, and can we use others in the community to help? Terri providing answers: tests we have plenty of tests. Decided as a collective decision – only test those who would need hospitalization and healthcare workers. Increase PPE and reduce exposure. Initial testing was cumbersome with long delays in getting results back, we encouraged them to shelter in place, many were off the 14-days before we got their test back. Testing abilities change every day. Diane – we're in line with CDC. Terri – no rhyme or reason on when we would get tests back. We will continue to keep the Board and the community informed. We are resource limited but have highly skilled EMS program. We obtained the Community Paramedics and will be able to use them moving forward. Conscious of how we can protect our front-line workers. We are robust in communication to our staff and work to keep them updated to stay safe. We are approved for 23 beds and we can do more if needed. Down valley ICU beds are filling, and they are days away from being full and we will need to be taking patients here. Bill: Team representing entities in the town, is communication better? Terri -yes, we are communicating and continue to do so. David: Larimer 93 positives, none are in Estes Park, shouldn't be overconfident, if someone has COVID 19 would we ship. Terri – can't share status of anyone in the hospital. David: bracing for the surge, ready and have plans in place. Ops team has worked around the clock to get it as good as we can get it. All areas are

working together, small facility is very nimble to take care of the community. David: continue social distancing to keep the curve flattened. Gary: one question, surgeon wanting to be contacted.

- Chief of Staff Update: Dr. Meyer hope the surge doesn't come, email Dr. Meyer if have needs to share. Shout out to Ops team, unrelenting planning team that didn't take a break. No different from any hospital but like to think that we are. Dealing with PPE shortage, if this hits it will be a big deal and community is trying to support. We can get things done and put plans in place. I would like to test everyone, however testing requires being able to get results back, all must assume the virus is here, if you're feeling sick – stay-home and not spread it. Testing requires us to use PPE, and what we learn will not change the course of how a patient is treated. Once you're admitted we need to know so we can always wear PPE to care for patient. Med Staff wants to know how to help because visits are down, and surgery is down. Doc want to work and be part of how thing will work – med staff is very engaged. Details of the surge plan, we are constantly refining the plan. Dr. Meyer wrote a letter encouraging them to shut down RMNP, to keep our resources for our community. My heart goes out to local businesses and hope we can somehow help. Encourage people to shut down lodging, to limit visitors. Bill: Thank John for writing letter. Shutting down RMNP stops us from being a magnet to get outside. Dr. Meyer: blessed to be able to get outside and social distance unlike bigger cities. Locals should know where to go, exercise, think positively, sleep, eat well and love on family. Question: if empty beds, can we take on non-COVID-19 patients. Terri: we have had conversations about this very thing. Many moving parts to making that happen. Vern: covered pretty adequately, downside we would lose beds, we will continue to explore. Tim: Have been in contact with down valley hospitals to set up a program. If down valley hospitals are running out of options, we can be an option.

- Estes Park Health Foundation Update: Kevin Mullen, EPH Foundation, EPH Board of Directors, adopted a new strategic plan Jan. 2020, Followed ppt. 3D mammography machine purchased and ready to be implemented according to Diagnostic Imaging. Set up emergency campaign for COVID-19 to cover a variety of expenses. Will wait for a later time to introduce Vern to donors. Diane: she feels that this is an extraordinary outreach. Kevin: Board and staff are dedicated to making EPH successful.

- Preview of Next Month's Colorado End-of-Life Options Act Annual: David: We had made a commitment to review this Act and revisit soon as soon as this more urgent matter is handled.

- Urgent Care Center Update – Barb Valente, Dir. UCC – Urgent Care Center is still on target to open in mid-May. May have delayed inspection for lab and pharmacy, we may have to send them to our other lab and pharmacy. Equipment is arriving but won't get in until mid-April to install. Have all full- and most part-time staff hired. Doing some virtual and real-time education and orientation in the next few weeks. David: will we have testing, possibly COVID-19 testing. Dr. Meyer: don't know why we wouldn't. Not sure we'd get testing by May, want to get at main hospital first. We'd like to test, not sure what will be available. Monty: any consideration for repurposing the UCC to handle COVID-19 patients. Tim: how do we segregate COVID and non COVID patients. Terri: it's been on our radar, but it hasn't been incorporated yet into the plan.

- Alarado Outpatient Clinic Update – Tim Cashman, CFO, Contractors are full-speed ahead to get us in by early May. Moving Rehab and Specialty also. Anticipating Certificate of Occupancy in April. Need clear fire inspection to get license from the state. Battle with CDOT and Town that is holding up the traffic light – scheduled for some time in the fall.

- Telehealth: David: is telehealth happening? Gary: we are working with UC Health to getting this up and running in the Clinic. There would be certain types of visits and patients as determined by the Clinic. Community Paramedics license in place to provide services for our community that we haven't before.

- Surgery Department Update – Terri Brandt Correia, CNO, have process in place for hyper-chlorination that is working very well. Everything from a water perspective is good. We are still doing cases that are emergent and cases that need to be performed. Restriction to access has caused a decline in surgery. ORs may become negative pressure space to help deal with COVID patients, should we need it for patient flow process. David: shows great innovation and continue to think about the community. Monty: is negative pressure in OR or Med/Surg. Terri: treat every patient as a COVID positive case and adjust handle that patient.

- 4QTR and End-of-year Financials, Tim Cashman CFO, Tim has provided an unaudited draft of year end financials. Move to a new system has been dramatic and impacted reconciliation and reporting. Auditors were on site and we hope to present audited statements in the April Board meeting. Unable to pull up financials. Tim: we are burning through cash and COVID will impact financials. Will talk about cash flow and how that has been impacted. David: big picture statements. Tim: our net bottom line are break even. Contract labor continues to be an issue. Pediatric on call cost $400,000. Hire and maintain nurses and CNAs for the Living Center has been costly. Sterilizer going down was an unanticipated event and costly. Financial forecast that covers the COVID costs? Tim: trying to build out a model for 30, 60 and 90 days to anticipate expenses and make adjustments.

- Financing Alarado Tenant Improvements & Initial Facility Master Plan Priorities – Tim we did seek financing for the building and have approved a lender is Bank of Colorado. Approved the resolution on Friday and Tim is asking the Board to approve. Interest is 1.1%. Tim read the resolution and asked Board to adopt the resolution.
- Approval of Financing Alarado Tenant Improvements & Initial Facility Master Plan Priorities – 2020-04, no change in amount and relationship with the bank, get to borrow $s as needed of the $5 million. David entertained a motion to adapt a resolution. Bill made motion and Monty seconded. Unanimous adoption.
- COVID-19 Possible Financial Impacts on Estes Park Health – Tim Cashman, CFO, just started on working through impact – expecting a revenue dip of around 55%, CAH – most have less than 60 days cash on hand, EPH days cash on hand is over 100 days. Expecting burn rate total of $4 million and will dip into reserves. Did receive news that the Feds approved funding support for hospitals, could potentially get 125% of our request. 6-month advance from Medicare to pay receipts. Expects it would be enough to hold us over – but we would need to pay it back. Another source of funding from FEMA to cover expenses associated with COVID-19. Surgery, Rehab, DI and Lab are impacted. And clinic visits are down. Inpatient census is down, and ED visits are down. Sandy: no question just want to make sure we keep quality up. Diane: Recognizes EPH is major employer and appreciates that EPH is working with staff to keep people employed. Does the lack of cash flow impact our debt ration – not at this time.

Open Action Items

Operations Significant Developments

Executive Summary – Significant Items Not Otherwise Covered: Nothing additional from SLT.

Medical Staff Credentialing Report
Credentialing committee met on February 26, one appointment, 4 reappoint and additional
Mr. Pinkham recommends approval of credentialing, Sandy Begley second approved by the Board.
Unanimous approval.

Review any Action List Items and Due Dates
Safe ballot drop off
Drop off up to the day of election
Write letter to Post Office to make sure they know ballot is coming.

Potential Agenda Items
Deferred Colorado End of Life Act Review
Revisit status of election
Audit report
First Quarter financials
Urgent Care Update and Alarado
COVID-19 Update

David: Thanks Gary for new technology to hold meeting virtually.
Two last comments:
Considering postponing the election. David: that would be complicated. No Districts are considering canceling elections. We have a mail ballot, so can still hold election.
Suggestions: helping with the drop off of box – locked metal drop box perhaps could be repurposed for the use. Tent for observer in parking lot to allow drop off ballot.

With no further business to be conducted, the March 30, 2020 Regular Board Meeting was adjourned at 6:33p.m. Next Board meeting is April 27, 2020 Motion Mr. Miller and second Mr. Pinkham to adjourn.

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David M. Batey, Chair
Estes Park Health Board of Directors

ESTES PARK HEALTH
BOARD OF DIRECTORS'

Special Board Meeting Minutes
April 15, 2020
3:00 p.m.
Timberline Conference Room

Board Members in Attendance
Dr. David Batey, Chair; Ms. Sandy Begley, Vice-Chair (via conference call); Dr. Monty Miller, Treasurer (via conference call); Ms. Diane Muno, Secretary; Mr. William Pinkham, Member-at-Large

Call to Order
The Board Special Meeting was Called to Order at 3:00 p.m. by Dr. Batey, Chairman of the Board of Directors; there was a quorum present. Notice of the Board Meeting was posted in accordance with the SUNSHINE Law Regulations.

A motion was made by Mr. Pinkham to move into Executive Session, pursuant to §24-6-402(4)(f), C.R.S., for the purpose of discussing a personnel matter; the motion was seconded by Ms. Muno. A verbal vote was requested – the ayes were unanimous, and the motion carried.

Executive Session
Executive Session Called-to-Order at 3:05 p.m.

With no further discussion to be conducted, a motion was made by Ms. Muno to adjourn Executive Session; the motion was seconded by Mr. Pinkham. A verbal vote was requested – the ayes were unanimous, and the motion passed; Executive Session was adjourned at 5:05 p.m.

The Board reconvened into Open at 5:05 p.m. With no further business to be conducted, A motion was made by Ms. Muno to adjourn the meeting at 5:05 p.m.; the motion was seconded by Mr. Pinkham. A verbal vote was requested – the ayes were unanimous, and the motion carried.

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David M. Batey, Chair
Estes Park Health Board of Directors

ESTES PARK HEALTH
BOARD OF DIRECTORS'

Special Board Meeting Minutes
April 17, 2020
3:00 p.m.
Timberline Conference Room

Board Members in Attendance
Dr. David Batey, Chair; Ms. Sandy Begley, Vice-Chair (via conference call); Dr. Monty Miller, Treasurer (via conference call); Ms. Diane Muno, Secretary (via conference call); Mr. William Pinkham, Member-at-Large

Call to Order
The Board Special Meeting was Called to Order at 3:09 p.m. by Dr. Batey, Chairman of the Board of Directors; there was a quorum present. Notice of the Board Meeting was posted in accordance with the SUNSHINE Law Regulations.

A motion was made by Mr. Pinkham to move into Executive Session, pursuant to §24-6-402(4)(f), C.R.S., for the purpose of discussing a personnel matter; the motion was seconded by Mr. Miller. A verbal vote was requested – the ayes were unanimous, and the motion carried.

Executive Session
Executive Session Called-to-Order at 3:10 p.m.

With no further discussion to be conducted, a motion was made by Mr. Pinkham to adjourn Executive Session; the motion was seconded by Mr. Miller. A verbal vote was requested – the ayes were unanimous, and the motion passed; Executive Session was adjourned at 3:42 p.m.

The Board reconvened into Open Session at 3:42 p.m. With no further business to be conducted, a motion was made by Mr. Pittman to adjourn the meeting at 3:43 p.m.; the motion was seconded by Mr. Miller. A verbal vote was requested – the ayes were unanimous, and the motion carried.

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David M. Batey, Chair
Estes Park Health Board of Directors

Report to Board of Directors—April 2020
From Estes Park Health Home Health Care, Estes Park Health Home Care, and Estes Park Health Hospice

I. People

This last quarter we hired/trained three new staff members—two fulltime homemaker/personal care providers, and a PRN physical therapist. We currently have three open positions—a fulltime homemaker/personal care provider, a part-time nurse, and PRN occupational therapist. We have a physical therapy traveler but have hired and will welcome to our team this month, a permanent fulltime physical therapist.

II. Quality

January 1, 2020 the new case-mix classification/payment calculation model for Medicare, the Patient-Driven Groupings Model (PDGM), became effective. Our team continues education on these changes as well as discussing how our agency can become more efficient.

Staff education is key to the health and growth of our department. We had 12 educational sessions by different presenters set up, but due to the COVID pandemic we've had to put all future sessions on hold. We did have three in-services early in the year: Compassion Fatigue by Herm Weaver, Chaplain; OASIS-D Functional Assessment—how to score by Lauren Dudas, physical therapist; and Community Paramedics by Sharon Lowry-Bielmaier & Mike Bielmaier.

Ongoing we evaluate our quality improvement projects/quality measures. For 2020, we removed some measures that showed improvement and added others that we will work on. For home health care, we removed both of the prior diabetes measures and added Improvement in Management of Oral Medications and Improvement in Pain Interfering with Activity. For hospice, we removed the LCD measure and added Care Plan to Check Meds/Refills at each visit. For home care, we removed the timely supervisory visit measure and added Client Satisfaction. These changes were approved at the Quality Management Committee meeting January 21. Our projects and progress towards our goals are discussed at staff meetings and reported every 6 months at the Estes Park Health's Quality Management Committee.

The current COVID-19 pandemic affects our department, as it does the whole world. We get daily updates from the EPH huddles and that information is shared with our staff daily. All staff ask screening questions before entering the homes for each visit, use great handwashing and infection control precautions, and all wear masks. As it currently stands, we will not enter a home or care for anyone that is a suspected or positive COVID-19 patient.

III. Service

We continue to provide quality patient care in the community through our three different types of services (skilled home health care, non-medical home care, and hospice). We service Estes Park and its surrounding mountain communities—Glen Haven, Drake, Storm Mountain, Allenspark, and Pinewood Springs.

We are currently providing non-medical personal care provider/homemaker services to some clients through the Boulder County Office on Aging grant program and the Larimer County Office on Aging grant program.

Year to date through March, our volumes compared to last year are: home health care up 6.2%, home care down 21.3%, and hospice up 5.4%. We continue to have steady volumes in the month of April.

IV. Financial

<u>2020 YTD Financials through February</u> (Three separate P&Ls for three agencies)
Home Health Care: Revenue ($151,081) is 3.6% above budget
Expenses ($222,306) are 25.8% above budget
Home Care (non-skilled): Revenue ($45,405) is 23.4% below budget
Expenses ($19,344) are 48.7% below budget
Hospice: Revenue ($89,828) is 17.1% above budget
Expenses ($49,025) are 26% below budget
<u>2020 YTD Roll-up for all three agencies through February</u>:
Total for all: Revenue ($286,314) is 1.6% above budget
Expenses ($290,675) are 3.5% above budget

The un-budgeted contract labor costs of the physical therapist traveler have greatly affected our YTD finances.

V. Community

As Bereavement Coordinator, Herm has been mentoring a hospice volunteer who has taken the lead in providing quarterly bereavement phone calls to those receiving bereavement services. Herm has also been working with a hospice volunteer on exploring the creation of a new time-limited grief group. Herm began planning for the annual HHC/Hospice staff retreat. Unfortunately, due to the world's situation right now with COVID-19, the retreat Is on hold. Herm continues to regularly connect and work with pastors, groups and churches in our community.

Alyssa Bergman, MSW and hospice Volunteer Coordinator, facilitates bi-weekly hospice Interdisciplinary meetings, as well as Volunteer meetings during the other weeks. She explored the volunteers' areas of expertise and interests and scheduled their presentations at some of the volunteer meetings. Furthermore, she has been reviewing and keeping all the volunteer files and education requirements up to date.

Nancy Bell, MSW, attended the local Journeys class that meets weekly at the Presbyterian Church, once to provide information and answer questions about hospice, and a second time to talk about music therapy and hospice. Nancy

scheduled education in-services with local and front range experts in a variety of fields, which have been rescheduled due to COVID-19. Nancy completes one hour of formal supervision from an LCSW monthly to deepen, strengthen, and broaden her skill set. Nancy continues to coordinate care for patients and families between hospitalizations, HHC, and hospice to assist in enhancing patient care.

Herm, Alyssa, and Nancy provide support for community members through hospice consultations, phone calls, and home visits. These three met with Sarah Bosko to plan community outreach where discussion centered around presentation format and ways to involve hospice volunteers in this outreach. Again, due to COVID 19, these plans are paused.

The Good Grief Group, facilitated by Herm Weaver, and the Caregiver Support Group, facilitated by Nancy Bell, meet twice a month at Good Samaritan. Both are holding their groups virtually during the current COVID stay-at-home orders.

ESTES PARK (PARK) HOSPITAL DISTRICT
May 5, 2020 Election Memo

To: Board of Directors, Park Hospital District

From: Sarah E. E. Shepherd, Designated Election Official

Date: April 22, 2020

Subject: May 5, 2020 Election Status

Dear Board:

Ballots were mailed out between the required April 13 and April 20 deadline, and are traced to be delivered by the end of the week of April 24 to the bulk of local residents. By the time of the meeting on the 27th, all ballots should have been delivered by USPS. We were set to mail on the early side of the deadline, but received a large amount of last minute changes (additions and deletions) to the voter rolls from Arapahoe County on April 13 and 14. Typically these large changes come in earlier, but were within the appropriate window for the County to update these list. Likely this was due to limits on human resources due to the COVID-19 State work-at-home orders. This is why we have the mailing window, and met the deadline. The mailing team and voter certification team worked long hours and their efforts are greatly appreciated.

Two (2) additional UOCAVA (Uniformed and Overseas Citizens Absentee Voting Act) ballots have been mailed or emailed to electors with the new list that the County provided.

To date, two (2) replacement ballots were mailed to voters in Estes Park on April 22, due to their regular mailing address being in another State, but they are local to Estes Park at this time per the stay-at-home orders and travel restrictions and advisements.

The local newspapers printed the election publication notice ahead of the April 15 deadline, and have been very helpful, again with limited human resources due to in-person office closures. This same notice for the election was post on the district's website at the top of the elections page: https://eph.org/about-us/board-of-directors/may-2020-board-election/. This notice details the timing for mailing and drop off locations and times through 7pm Election Day, May 5.

Ballots can be dropped off or mailed according to the election notice. After speaking with Kim Chase, the Estes Park Postmaster, we have been assured that unvoiced ballots will be delivered to voters on the same day they are received but the post office, and that voted ballots will be delivered from Estes Park to Denver the day they are collected, and then onto our office for processing. Her estimate would be to allow for 2 days to ensure ballots are received by mail on or before election day (Friday May 1). If ballots are mailed after Friday May 1, the Estes Park postal workers will make their best effort to deliver ballots directly to the Hospital for deposit into the drop-off ballot box (again only if these voted ballots are picked up between Friday May 1, and Tuesday May 5).

Vern, Randy and Sherrie have been wonderful in their efforts to assist in forwarding requests and questions to our offices, taking in and putting out the ballot box each day, and keeping replacement ballots on site in case an emergency replacement ballot issuance is necessary between now and Election Day. All have been up to the task of effective communication as well as becoming quick studies. Vern and/or Randy will deliver the ballot box for counting after the close of the local ballot drop-off at 7pm on Election Day. President Batey has been actively working with us all. They all deserve a huge amount of thanks.

In order to quickly and safely process ballots, the hospital staff who are assisting as judges, Vern, Randy, Sherrie, will notify our office if the ballot box begin filling up, so we can plan ahead for a timeline count on Election Day.

I plan to attend the April 27 virtual regular district board meeting to answer questions and discuss counting procedures in line with CDC and State guidelines.

I have requested that Vice-President Begley and Sherrie Kelley serve as the Canvass Board to assist me in certifying the final election results.

The May regular board meeting will be the time to swear in re-elected or newly elected Directors after the election results have been confirmed. All information and documents will be provided at that meeting and submitted to the State afterward according to the Election Calendar.

RESOLUTION 2020-05

APPROVAL OF SBA LOAN FROM PAYROLL PROTECTION PROGRAM AS SUPPORT FOR COVID-19 EXPENSES

WHEREAS, the Park Hospital District, d/b/a Estes Park Health (the "District"), seeks approval of a loan of $4,800,000 from the Small Business Administration and the Payroll Protection Program of the 2020 CARES Act, for seventeen (17) months (financed through the Bank of Colorado on substantially the terms attached hereto as Exhibit A), for the purposes of adequate funds for the payroll cost over an eight (8) week period; and

WHEREAS, with compliance of specific terms noted in the Agreement, this loan is forgivable; and

WHEREAS, the Finance Committee of this Board of Directors has recommended the Financing in the form presented; and

WHEREAS, this Board of Directors desires to authorize certain officers of the District to approve and negotiate additional details of the Financing.

NOW, THEREFORE, this Board of Directors resolves as follows:

RESOLVED, that the terms, conditions and provisions of the Financing are in all respects authorized and approved and recommended.

FURTHER RESOLVED, that the Chief Executive Officer and the Chief Financial Officer of the District are authorized to take all such further action and to execute, deliver, file and record as appropriate all such documents, instruments, uniform commercial code financing statements, certificates and other documents, in the name and on behalf of the District or otherwise as in their judgment shall be necessary or convenient to carry out the intent and to accomplish the purposes of these resolutions and the Financing.

ADOPTED by the Board of Directors of Park Hospital District, d/b/a Estes Park Health this 24th day of April 2020.

PARK HOSPITAL DISTRICT
d/b/a ESTES PARK HEALTH

By: _____
David M. Batey, Chair

ATTEST:

_____
Diane Muno, Secretary

EXHIBIT A

ATTACH TERM SHEET

U.S. Small Business Administration

NOTE

SBA Loan #	96808371-09
Bank Loan #	7770002690
SBA Loan Name	Park Hospital District
Date	04/24/20
Loan Amount	$ 4,800,000.00
Interest Rate	1.00%
Borrower	Park Hospital District
Operating Company	N/A
Lender	Bank of Colorado

1. PROMISE TO PAY:

In return for the Loan, Borrower promises to pay to the order of Lender the amount of Four Million Eight Hundred Thousand _____ Dollars, interest on the unpaid principal balance, and all other amounts required by this Note.

2. DEFINITIONS:

"Collateral" means any property taken as security for payment of this Note or any guarantee of this Note.

"Guarantor" means each person or entity that signs a guarantee of payment of this Note.

"Loan" means the loan evidenced by this Note.

"Loan Documents" means the documents related to this loan signed by Borrower, any Guarantor, or anyone who pledges collateral.

"SBA" means the Small Business Administration, an Agency of the United States of America.

3. PAYMENT TERMS:

Borrower must make all payments at the place Lender designates. The payment terms for this Note are:

Borrower will pay this loan in 17 payments of $ $ 270,177.41 each payment and an irregular last payment. Borrower's first payment is due 11/24/2020 and all subsequent payments are due on the same day of each month after that. Borrower's final payment will be due on 04/24/2022 and will be for all principal and all accrued interest not yet paid. Payments include principal and interest. Unless otherwise agreed or required by applicable law, payments will be applied first to any accrued unpaid interest, then to principal. Borrower will pay at Lender's address. If a payment is made consistent with Lender's payment instructions but received after 5:00p.m. based on your branch time zone, Lender will credit Borrower's payment on the next business day.

INTEREST CALCULATION METHOD. Interest on the Note is computed on a 365/360 basis; that is, by applying the ratio of the interest rate over a year of 360 days, multiplied by the outstanding principal balance, multiplied by the actual number of days the principal balance is outstanding. All interest payable under this Note is computed using this method.

4. DEFAULT:

Borrower is in default under this Note if Borrower does not make a payment when due under this Note, or if Borrower or Operating Company:

A. Fails to do anything required by this Note and other Loan Documents;

B. Defaults on any other loan with Lender;

C. Does not preserve, or account to Lender's satisfaction for, any of the Collateral or its proceeds;

D. Does not disclose, or anyone acting on their behalf does not disclose, any material fact to Lender or SBA;

E. Makes, or anyone acting on their behalf makes, a materially false or misleading representation to Lender or SBA;

F. Defaults on any loan or agreement with another creditor, if Lender believes the default may materially affect Borrower's ability to pay this Note;

G. Fails to pay any taxes when due;

H. Becomes the subject of a proceeding under any bankruptcy or insolvency law;

I. Has a receiver or liquidator appointed for any part of their business or property;

J. Makes an assignment for the benefit of creditors;

K. Has any adverse change in financial condition or business operation that Lender believes may materially affect Borrower's ability to pay this Note;

L. Reorganizes, merges, consolidates, or otherwise changes ownership or business structure without Lender's prior written consent; or

M. Becomes the subject of a civil or criminal action that Lender believes may materially affect Borrower's ability to pay this Note.

5. LENDER'S RIGHTS IF THERE IS A DEFAULT:

Without notice or demand and without giving up any of its rights, Lender may:

A. Require immediate payment of all amounts owing under this Note;

B. Collect all amounts owing from any Borrower or Guarantor;

C. File suit and obtain judgment;

D. Take possession of any Collateral; or

E. Sell, lease, or otherwise dispose of, any Collateral at public or private sale, with or without advertisement.

6. LENDER'S GENERAL POWERS:

Without notice and without Borrower's consent, Lender may:

A. Bid on or buy the Collateral at its sale or the sale of another lienholder, at any price it chooses;

B. Incur expenses to collect amounts due under this Note, enforce the terms of this Note or any other Loan Document, and preserve or dispose of the Collateral. Among other things, the expenses may include payments for property taxes, prior liens, insurance, appraisals, environmental remediation costs, and reasonable attorney's fees and costs. If Lender incurs such expenses, it may demand immediate repayment from Borrower or add the expenses to the principal balance;

C. Release anyone obligated to pay this Note;

D. Compromise, release, renew, extend or substitute any of the Collateral; and

E. Take any action necessary to protect the Collateral or collect amounts owing on this Note.

7. WHEN FEDERAL LAW APPLIES:

When SBA is the holder, this Note will be interpreted and enforced under federal law, including SBA regulations. Lender or SBA may use state or local procedures for filing papers, recording documents, giving notice, foreclosing liens, and other purposes. By using such procedures, SBA does not waive any federal immunity from state or local control, penalty, tax, or liability. As to this Note, Borrower may not claim or assert against SBA any local or state law to deny any obligation, defeat any claim of SBA, or preempt federal law.

8. SUCCESSORS AND ASSIGNS:

Under this Note, Borrower and Operating Company include the successors of each, and Lender includes its successors and assigns.

9. GENERAL PROVISIONS:

A. All individuals and entities signing this Note are jointly and severally liable.

B. Borrower waives all suretyship defenses.

C. Borrower must sign all documents necessary at any time to comply with the Loan Documents and to enable Lender to acquire, perfect, or maintain Lender's liens on Collateral.

D. Lender may exercise any of its rights separately or together, as many times and in any order it chooses. Lender may delay or forgo enforcing any of its rights without giving up any of them.

E. Borrower may not use an oral statement of Lender or SBA to contradict or alter the written terms of this Note.

F. If any part of this Note is unenforceable, all other parts remain in effect.

G. To the extent allowed by law, Borrower waives all demands and notices in connection with this Note, including presentment, demand, protest, and notice of dishonor. Borrower also waives any defenses based upon any claim that Lender did not obtain any guarantee; did not obtain, perfect, or maintain a lien upon Collateral; impaired Collateral; or did not obtain the fair market value of Collateral at a sale.

H. Borrower hereby agrees to execute and deliver to Lender any other documents or instruments which may be required by the SBA to further document the loan evidenced by this Note, including any modification or change in terms of this Note, required by the SBA or any SBA regulations or guidance issued after the date of this Note.

I. ATTORNEYS' FEES; EXPENSES. Lender may hire or pay someone else to help collect this Note if Borrower does not pay. Borrower will pay Lender the reasonable costs of such collection. This includes, subject to any limits under applicable law, Lender's attorneys' fees and Lender's legal expenses, whether or not there is a lawsuit, including without limitation attorneys' fees and legal expenses for bankruptcy proceedings (including efforts to modify or vacate any automatic stay or injunction), and appeals. If not prohibited by applicable law, Borrower also will pay any court costs, in addition to all other sums provided by law.

J. JURY WAIVER. Lender and Borrower hereby waive the right to any jury trial in any action, proceeding, or counterclaim brought by either Lender or Borrower against the other.

K. DISHONORED ITEM FEE. Borrower will pay a fee to Lender of $28.00 if Borrower makes a payment on Borrower's loan and the check or preauthorized charge with which Borrower pays is later dishonored.

L. RIGHT OF SETOFF. To the extent permitted by applicable law, Lender reserves a right of setoff in all Borrower's accounts with Lender (whether checking, savings, or some other account). This includes all accounts Borrower holds jointly with someone else and all accounts Borrower may open in the future. However, this does not include any IRA or Keogh accounts, or any trust accounts for which setoff would be prohibited by law. Borrower authorizes Lender, to the extent permitted by applicable law, to charge or setoff all sums owing on the debt against any and all such accounts, and, at Lender's option, to administratively freeze all such accounts to allow Lender to protect Lender's charge and setoff rights provided in this paragraph.

M. CONSENT. Upon any change in the terms of this Note, and unless otherwise expressly stated in writing, no party who signs this Note, whether as maker, guarantor, accommodation maker or endorser, shall be released from liability. All such parties agree that Lender may renew or extend (repeatedly and for any length of time) this loan or release any party or guarantor or collateral; or impair, fail to realize upon or perfect Lender's security interest in the collateral; and take any other action deemed necessary by Lender without the consent of or notice to anyone. All such parties also agree that Lender may modify this loan without the consent of or notice to anyone other than the party with whom the modification is made. The obligations under this Note are joint and several.

N. FURTHER ASSURANCES. The undersigned Borrower, for and in consideration of the Lender funding the closing of this loan, hereby agrees to execute and deliver to Lender any other documents or instruments which may be required by the SBA to further document the loan evidenced by this Note, including any modification or change in terms of this Note, required by the SBA or any SBA regulations or guidance issued after the date of this Note.

10. STATE-SPECIFIC PROVISIONS:

Colorado Borrowers:
GOVERNING LAW. This Note will be governed by federal law applicable to Lender and, to the extent not preempted by federal law, the laws of the State of Colorado without regard to its conflicts of law provisions. This Note has been accepted by Lender in the State of Colorado.
CHOICE OF VENUE. If there is a lawsuit, Borrower agrees upon Lender's request to submit to the jurisdiction of any state or federal courts in the State of Colorado.

Arizona Borrowers:
GOVERNING LAW. This Note will be governed by federal law applicable to Lender and, to the extent not preempted by federal law, the laws of the State of Arizona without regard to its conflicts of law provisions. This Note has been accepted by Lender in the State of Arizona.
CHOICE OF VENUE. If there is a lawsuit, Borrower agrees upon Lender's request to submit to the jurisdiction of any state or federal courts in the State of Arizona.

New Mexico Borrowers:
GOVERNING LAW. This Note will be governed by federal law applicable to Lender and, to the extent not preempted by federal law, the laws of the State of New Mexico without regard to its conflicts of law provisions. This Note has been accepted by Lender in the State of New Mexico.
CHOICE OF VENUE. If there is a lawsuit, Borrower agrees upon Lender's request to submit to the jurisdiction of any state or federal courts in the State of New Mexico.

Nebraska Borrowers:
NOTICE - WRITTEN AGREEMENTS. A credit agreement must be in writing to be enforceable under Nebraska law. To protect Borrower and Lender from any misunderstandings or disappointments, any contract, promise, undertaking or offer to forbear repayment of money or to make any other financial accommodation in connection with this loan of money or grant or extension of credit, or any amendment of, cancellation of, waiver of, or substitution for any or all of the terms or provisions of any instrument or document executed in connection with this loan of money or grant or extension of credit must be in writing to be effective.
GOVERNING LAW. This Note will be governed by federal law applicable to Lender and, to the extent not preempted by federal law, the laws of the State of Colorado without regard to its conflicts of law provisions. This Note has been accepted by Lender in the State of Colorado.
CHOICE OF VENUE. If there is a lawsuit, Borrower agrees upon Lender's request to submit to the jurisdiction of any state or federal courts in the State of Colorado.

Kansas Borrowers:
By signing this document each party represents and agrees that: (A) the written loan agreement represents the final agreement between the parties, (B) there are no unwritten oral agreements between the parties, and (C) the written loan agreement may not be contradicted by evidence of any prior, contemporaneous, or subsequent oral agreements or understandings of the parties.
GOVERNING LAW. This Note will be governed by federal law applicable to Lender and, to the extent not preempted by federal law, the laws of the State of Colorado without regard to its conflicts of law provisions. This Note has been accepted by Lender in the State of Colorado.
CHOICE OF VENUE. If there is a lawsuit, Borrower agrees upon Lender's request to submit to the jurisdiction of any state or federal courts in the State of Colorado.

Jury Waiver:
Lender and Borrower hereby waive the right to any jury trial in any action, proceeding, or counterclaim brought by either Lender or Borrower against the other.

11. BORROWER'S NAME(S) AND SIGNATURE(S):

By signing below, each individual or entity becomes obligated under this Note as Borrower.

BORROWER:

_____

Authorized Signer

_____

Authorized Signer

Thank you for allowing Bank of Colorado/Pinnacle Bank to help you with your Paycheck Protection Program (PPP) Loan. We hope the PPP loan program helps you and your business through these trying times.

Now that your loan is funded, we want to provide you with some reminders and helpful resources to ensure maximum forgiveness on your loan.

Please note that the forgiveness of your loan is determined by the rules set forth by the SBA in response to the implementation of sections 1102 and 1106 of the CARES Act, not Bank of Colorado/Pinnacle Bank, and are subject to change by the SBA. Please refer to SBA.gov and Treasury.gov for more details and any updates.

What can I use my PPP Loan for?

- Payroll costs, including benefits.
- **Interest** on mortgage payments, if mortgage was outstanding before February 15, 2020.
- Rent, under lease agreements in force before February 15, 2020.
- Utilities, for which service began before February 15, 2020.

How much of my loan will be forgiven? All of it if you meet the following requirements:

- Use funds **ONLY** for the items mentioned above,
- Funds are used **within** 8 weeks of loan closing,
- Employee levels are maintained or back to previous levels by June 30, 2020, and
- Employee compensation levels are not decreased more than 25%, for any employee that made less than $100,000 annualized in 2019.

How will I end up owing money on my loan?

- If you do not maintain your staff and payroll.
    - Loan forgiveness will be reduced if you decrease the number of full-time employees.
    - Loan forgiveness will also be reduced if you decrease salaries/wages by more than 25% for any employee that made less than $100,000 annualized in 2019.

How do I request loan forgiveness?

- Submit a request to the Bank of Colorado/Pinnacle Bank lender servicing the loan.
- In that request, include certifying documentation showing number of full-time employees, pay rates, as well as the payments on eligible mortgage, lease, and utility obligations during the 8 weeks following your loan funding.
- You must certify that all documentation provided is true and correct.
- A decision on forgiveness will be made within 60 Days of receipt.

To help you track your loan usage and ensure maximum forgiveness, we've created a PPP Loan Tracker Tool that can be downloaded on our website, https://www.bankofcolorado.com/CARES.

Thank you for being a Bank of Colorado/Pinnacle Bank customer!

This Statement of Policy is Posted

In Accordance with Regulations of the

Small Business Administration

This Organization Practices

Equal Employment Opportunity

We do not discriminate on the ground of race, color, religion, sex, age, disability or national origin in the hiring, retention, or promotion of employees; nor in determining their rank, or the compensation or fringe benefits paid them.

This Organization Practices

Equal Treatment of Clients

We do not discriminate on the basis of race, color, religion, sex, marital status, disability, age or national origin in services or accommodations offered or provided to our employees, clients or guests.

These policies and this notice comply with regulations of the United States Government.

Please report violations of this policy to :

Administrator

Small Business Administration

Washington, D.C. 20416

In order for the public and your employees to know their rights under 13 C.F.R Parts 112, 113, and 117, Small Business Administration Regulations, and to conform with the directions of the Administrator of SBA, this poster must be displayed where it is clearly visible to employees, applicants for employment, and the public.

Failure to display the poster as required in accordance with SBA Regulations may be considered evidence of noncompliance and subject you to the penalties contained in those Regulations.

SBA FORM 722 (10-02) REF: SOP 9030 PREVIOUS EDITIONS ARE OBSOLETE
This form was electronically produced by Elite Federal Inc,.

Item 6.3

Estes Park Health

2019 Audit Results and Report to the Board of Directors

WEALTH ADVISORY | OUTSOURCING | AUDIT, TAX, AND CONSULTING

Create Opportunities

We promise to know you and help you.

Table of Contents

Required Communications to Governance & Internal Control Matters

Required Communications

Topic	Communication
Our responsibility under Generally Accepted Auditing Standards	• Express an opinion on the fair presentation of the financial statements in conformity with GAAP • Plan and perform the audit to obtain reasonable, non absolute assurance that the financial statements are free of material misstatement • Evaluate internal control over financial reporting • Utilize a risk based audit approach • Communicate significant matters to appropriate parties
Planned Scope and Timing of the Audit	• Performed the audit according to the planned scope and timing previously discussed
Other Information in Documents Containing the Audited Financial Statements	• Financial statements may only be used in their entirety • Our approval is required to use our audit report in a client prepared document • We have no responsibility to perform procedures beyond those related to the financial statements • No opinion places of required supplemental (RSI) information

Required Communications

Topic	Communication
Significant Accounting Policies	• Management is responsible for the accounting policies of the organization • Accounting policies are outlined in Note 1 to the financial statements • No significant changes to the accounting policies during the year • Accounting policies deemed appropriate • No unusual transactions occurred
Significant Accounting Estimates	• An area of focus under a risk based audit approach • Significant estimates include: Allowance for contractual adjustment and bad debts, useful lives assigned to fixed assets, self-funded health insurance liability, and third-party settlements • Estimates determined by management based on their knowledge and experience • No management bias indicated • Estimates were deemed reasonable • Estimate uncertainty is disclosed in the financial statements
Significant Financial Statement Disclosures	• **No** sensitive disclosures • **No** significant risks, exposures, or uncertainties • **No** unusual transactions • Disclosures are neutral, consistent, and clear

Required Communications

Topic	Communication
Management Representation Letter	• Management will provide signed representation letter prior to finalization of the audit report
Supplemental Information	• Budget and actual revenues and expenses • Engaged to report in relation to the financial statements as a whole • Method of preparing has not changed from prior year, supplemental information reconciled to the financial statements • Supplemental information appears appropriate and complete in relation to our audit
Other	• No difficulties encountered in performing the audit • No issues discussed prior to retention as independent auditors • No disagreements with management regarding accounting, reporting, or other matters • No consultations with other independent auditors • No other findings or issues were discussed with, or communicated to, management

Internal Control Matters

Topic	Communication
Purpose	• Express an opinion on the financial statements, not on the effectiveness of internal controls. • Our consideration of internal controls was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore material weaknesses or significant deficiencies may exist that were not identified. In addition, because of inherent limitations in internal control, including the possibility of management override of controls, misstatements due to fraud or error may occur and not be detected by such controls.
Material Weakness	• Reasonable possibility that a material misstatement would not be prevented, or detected and corrected on a timely basis.
Significant Deficiencies	• Less significant than a material weakness, yet important enough to merit the attention of governance.
Restricted Use	• This communication is intended solely for the information and use of management, the audit committee, and others within the Organization, and is not intended to be, and should not be, used by anyone other than these specified parties.
Results	• No Material Weaknesses Identified

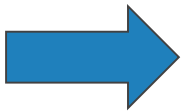
General Internal Control Comments

- Review of journal entries
- Improvements around IT controls in fiscal year 2019
  - Recommend performing external penetration testing in 2020

Your Business: Financial Ratios

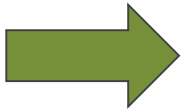
Financial Ratios – Comparative Data Used

- Estes Park Health (EPH)
  - $48.3 Million Net Patient Service Revenue



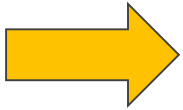
2016 - 2019

- CliftonLarsonAllen CAH Clients (CLA)
  - CAH Hospitals with less than $75 million of net patient service revenue



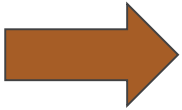
2016 - 2018

- CliftonLarsonAllen Gold Standard (GS)
  - 1,300 fiscal year reports analyzed and used in preparation of ratios and benchmarks
  - 35 Gold Standard Facilities



2016 - 2018

- Colorado Critical Access Hospitals (CO-CAH)
  - Colorado CAH data extracted as part of the CliftonLarsonAllen gold standard study

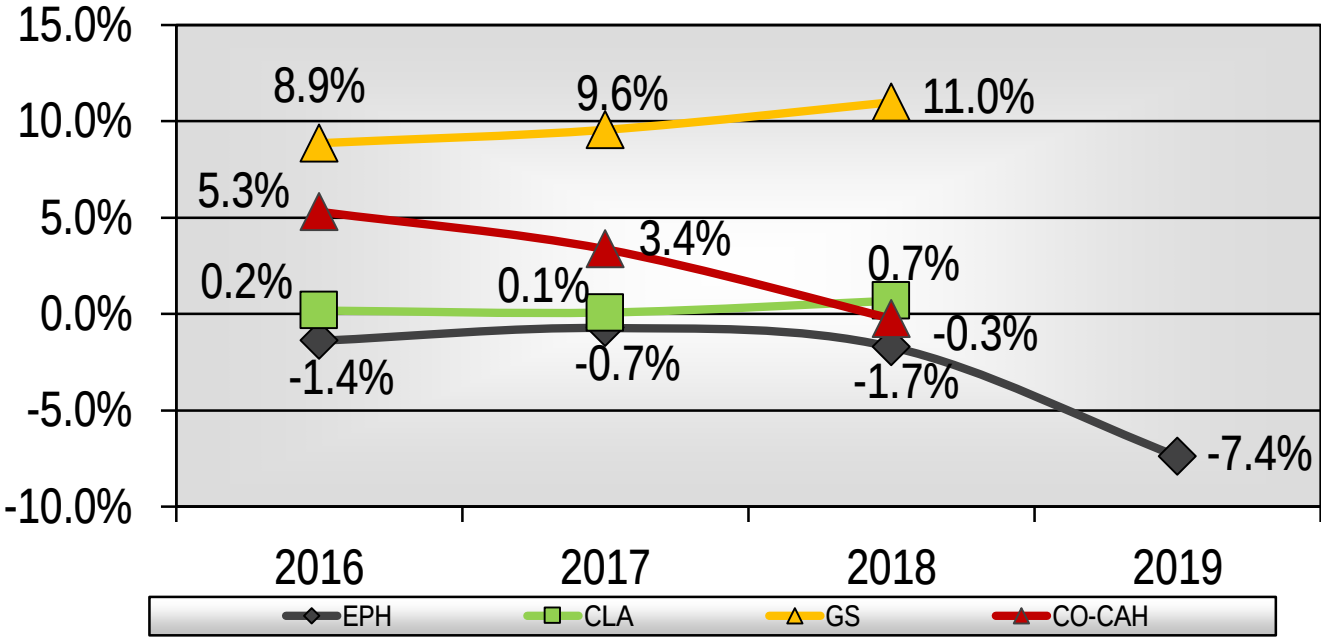


2016 - 2018

Operating Margin

Definition:

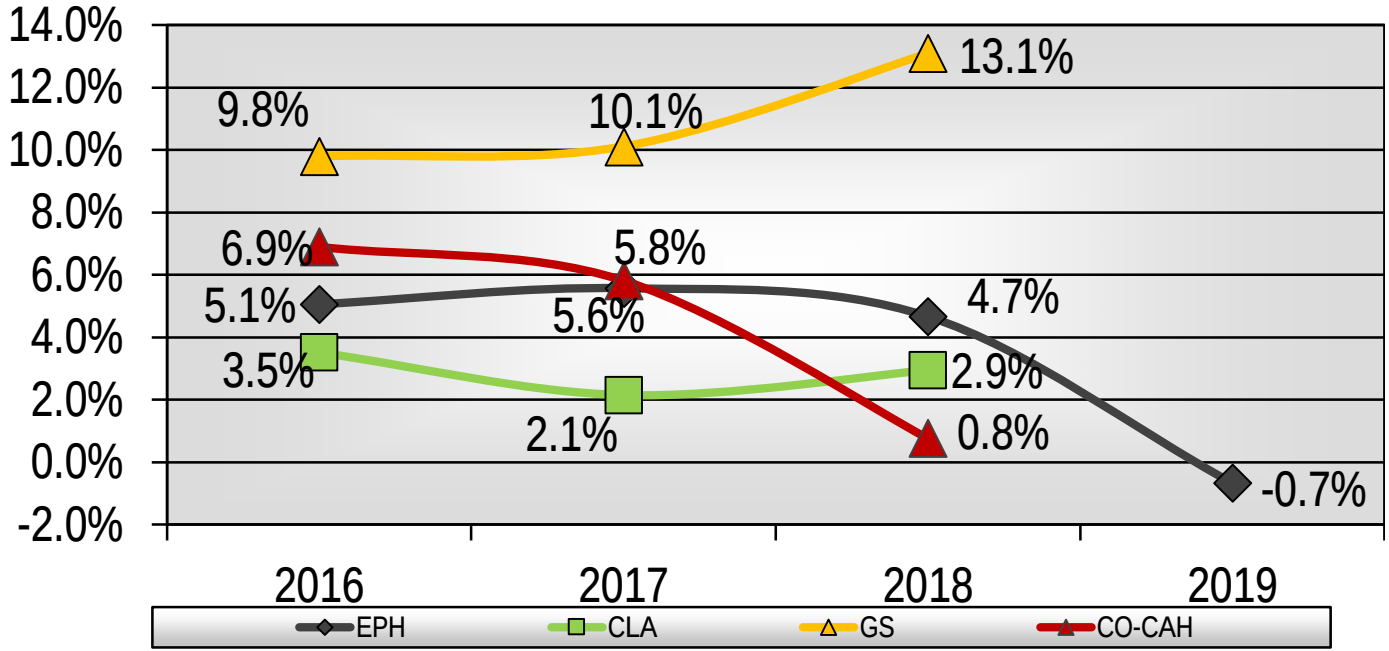
The ratio is operating income as a percentage of net patient service revenue plus other operating revenues. It is used to report the facility's returns on revenues which relate to the main purpose of operations.



Total Margin

Definition:

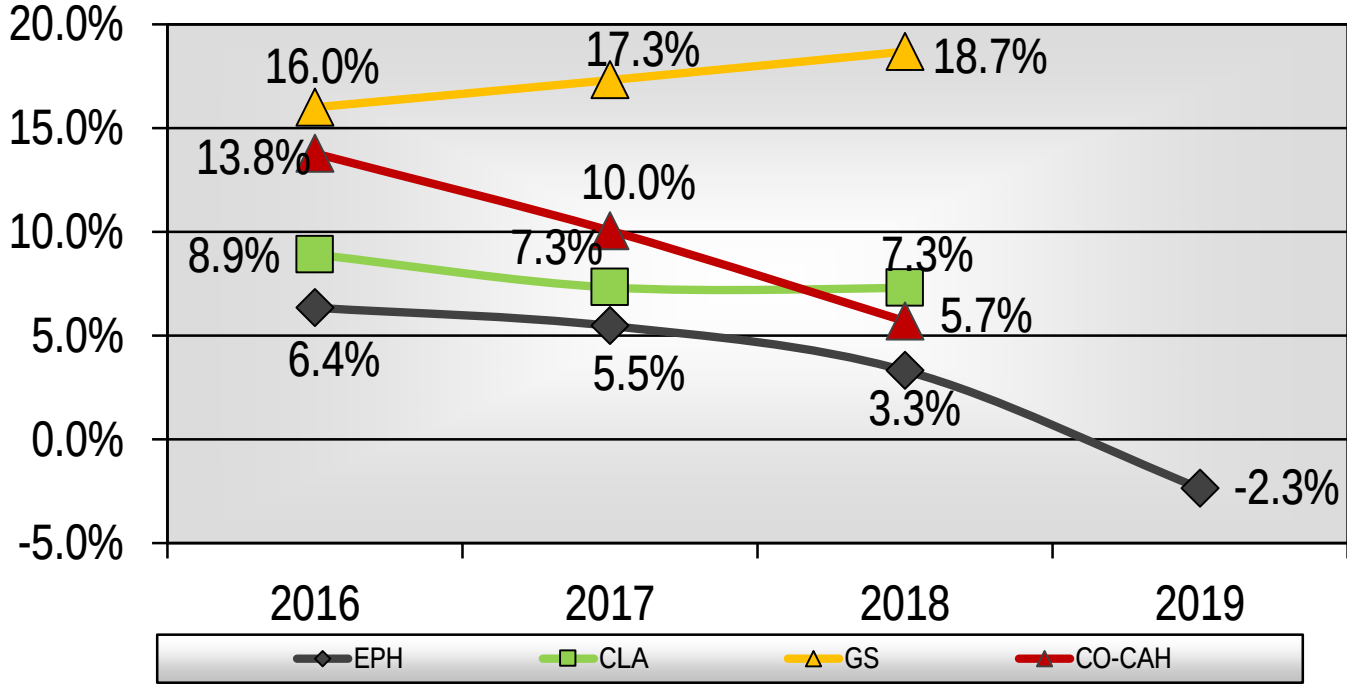
Total margin reflects excess of revenues over expenses as a percentage of total revenues, including non-operating revenues.



Operating EBIDA

Definition:

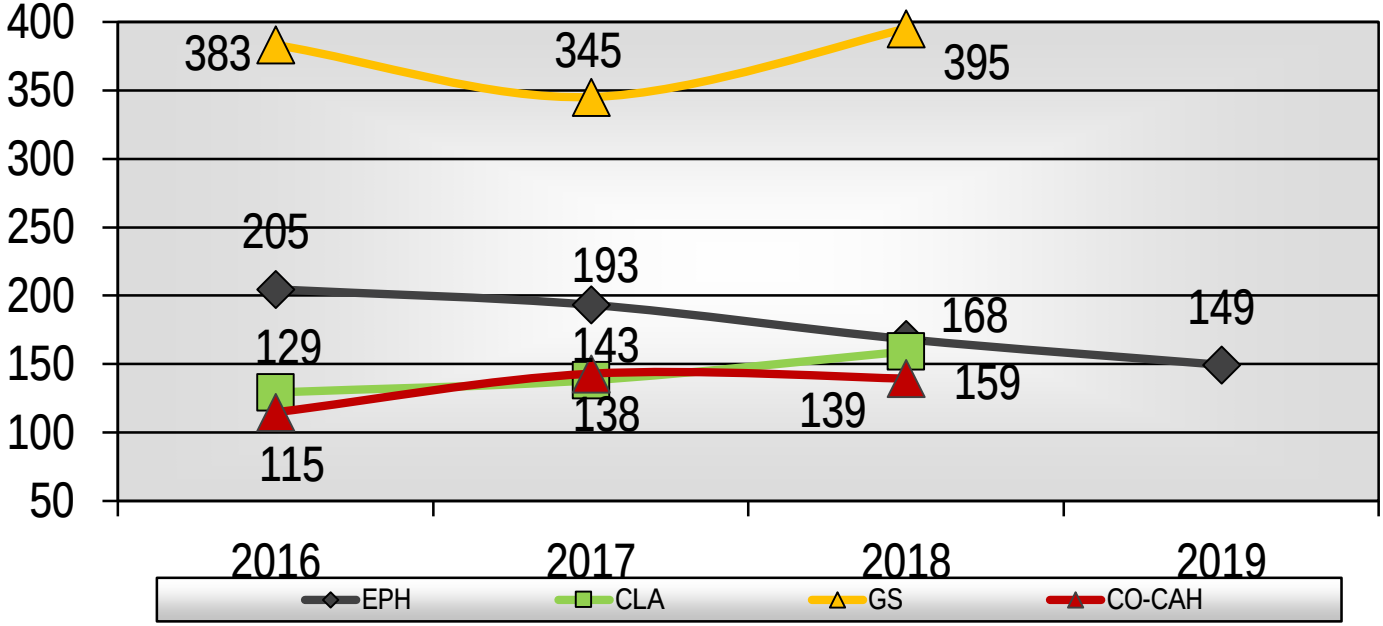
EBIDA represents Earnings (excess (deficit) of revenue over expenses) Before Interest, Depreciation, and Amortization divided by total revenues. This ratio is often used when evaluating debt capacity.



Days Cash on Hand (All Sources)

Definition:

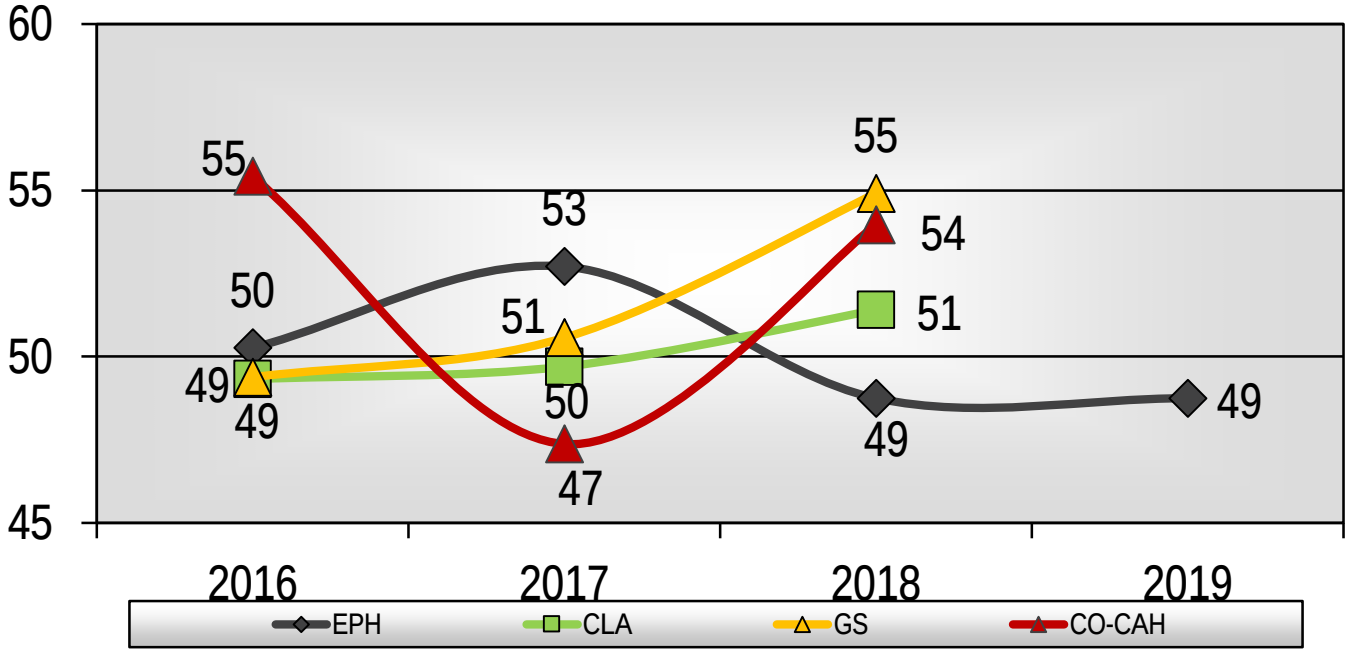
Days Cash on Hand measures the number of days of average cash expenses that the facility maintains in cash and amounts reserved for capital improvements. High values usually imply a greater ability to meet both short-term obligations and long-term capital replacement needs.



Net Days in Accounts Receivable

Definition:

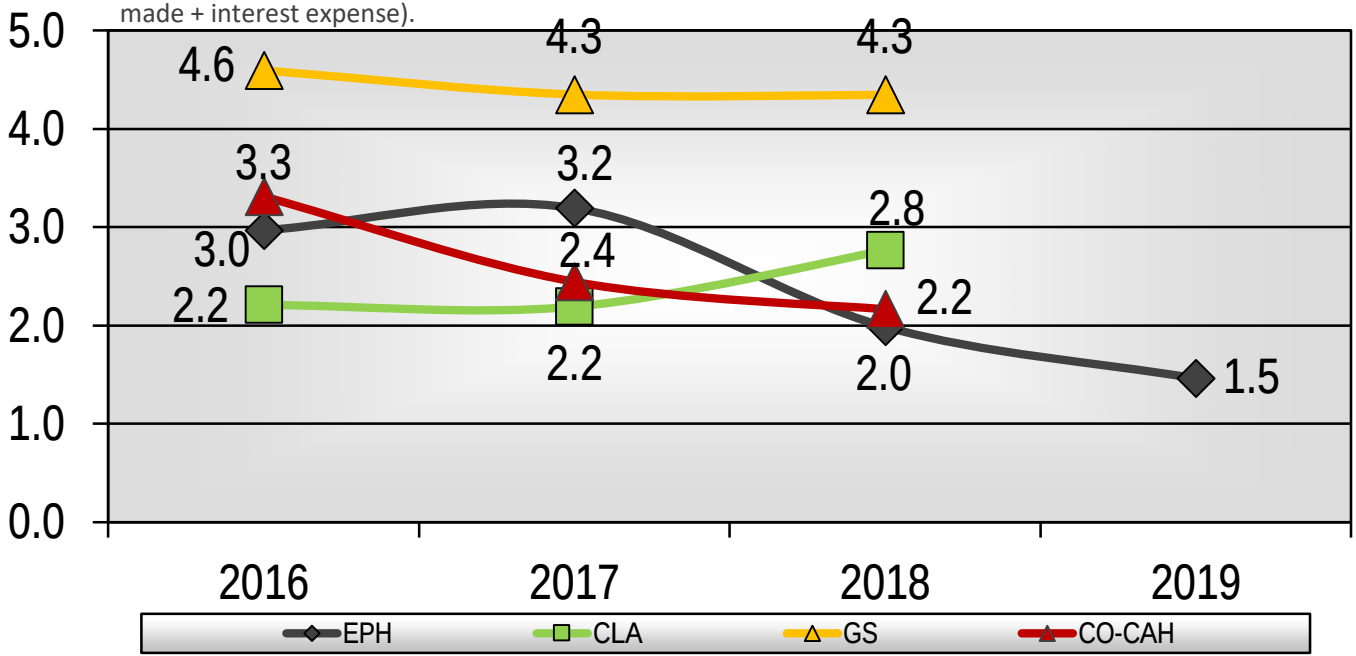
Days in patient accounts receivable is defined as the average time that receivables are outstanding, or the average collection period.



Debt Service Coverage Ratio

Definition:

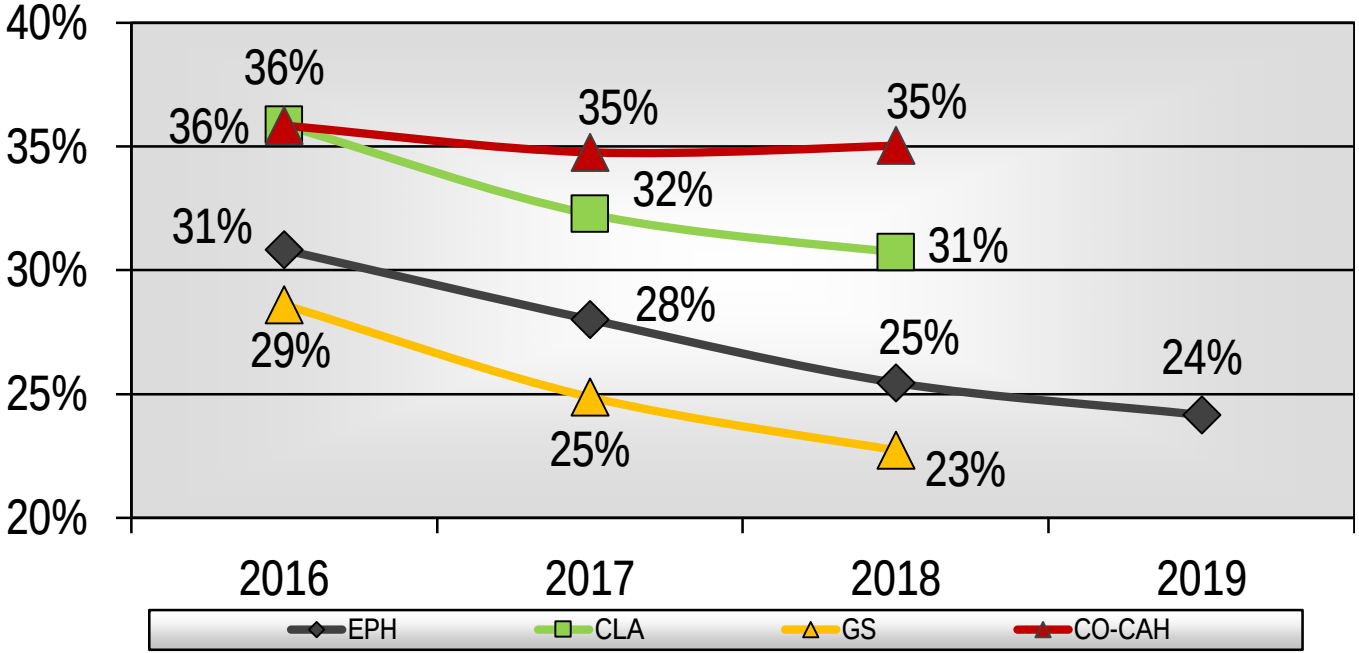
Debt service coverage is calculated as income available for debt services (net income + depreciation and amortization + interest expense) divided by the annual debt service requirements (principal payments made + interest expense).



Debt to Capitalization

Definition:

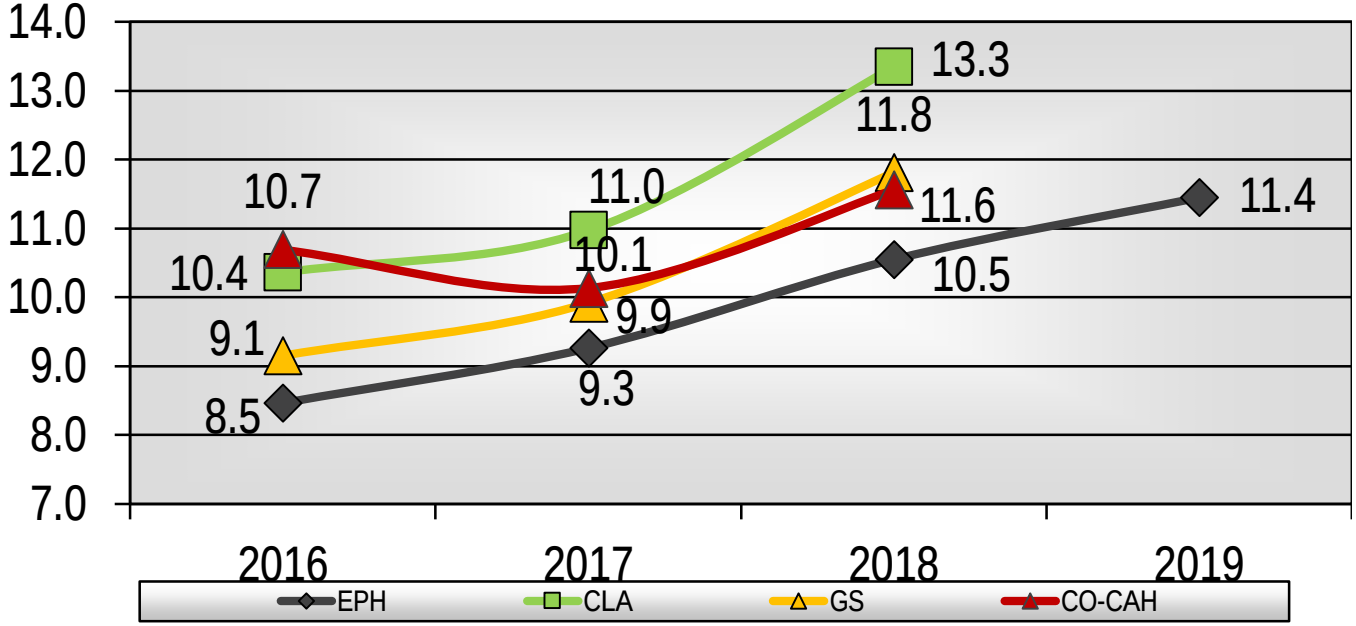
This ratio is defined as the proportion of long-term debt divided by long-term debt plus total net assets. Higher values for this ratio imply a greater reliance on debt financing and may imply reduced ability to carry additional debt.



Average Age of Plant

Definition:

Average age of plant attempts to approximate the average age of an organization's fixed assets. A low value is considered to be desirable as it indicates a newer facility.



Understanding Your Industry: 2019 Health Policy Outlook

Azar's Top Priorities as Leader of HHS

- Sky rocketing drug prices
- Health care affordability and availability
- **Shifting Medicare to paying for health and outcomes**
- Tackling the opioid epidemic

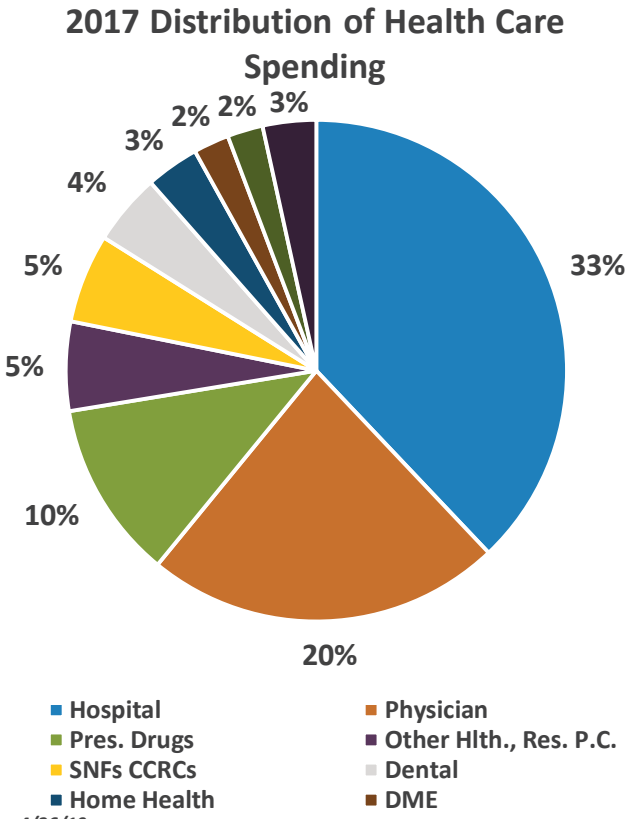
Additional Goals

- Increasing interoperability and accessibility of health care information
- Increasing transparency
- Reducing regulatory burden, increasing flexibility
- Bringing patients into equation

As Secretary of HHS, Azar is a guiding force over various health care agencies, including: CMS, CMMI, CDC, NIH, FDA…

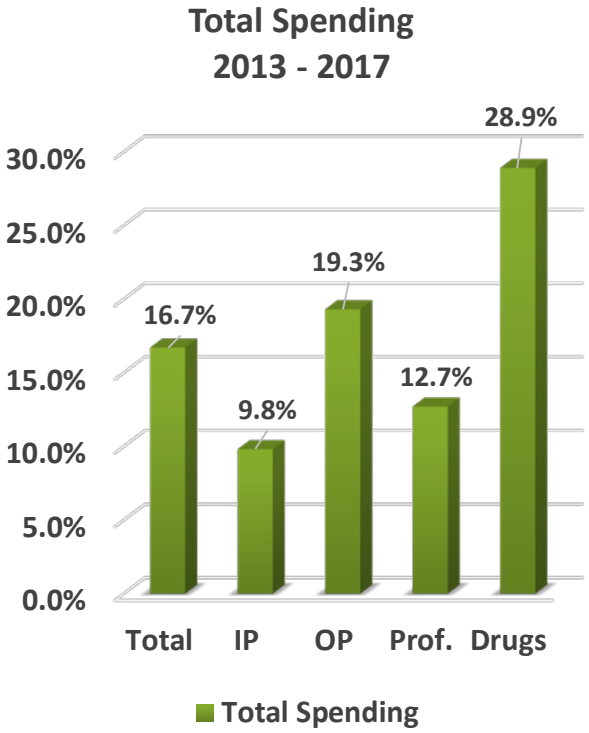
Nat'l Health Expenditures Continue to Rise *

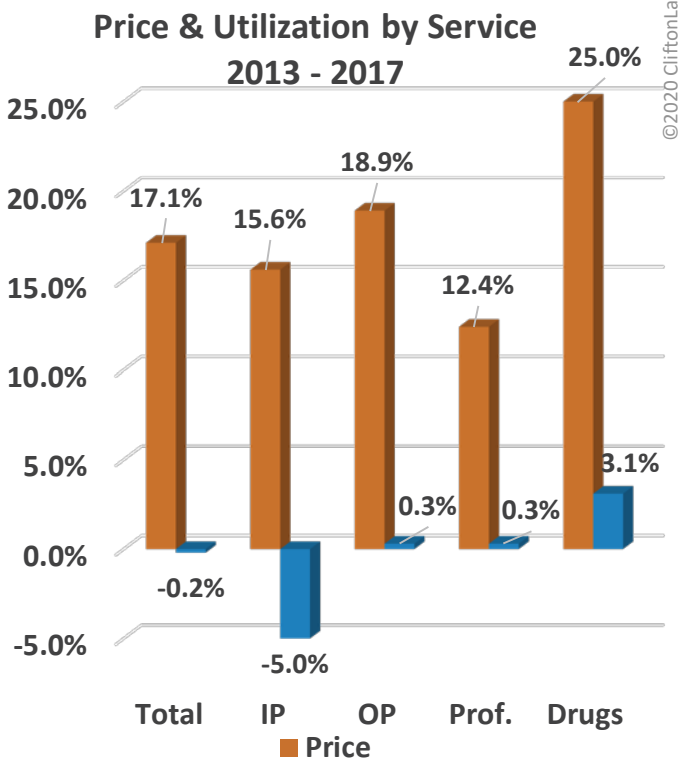
- In 2017, U.S. Health Care spending grew 3.9%, reaching $3.5 Trillion
- Spending Increase by Service Type:
  - Hospital Care 4.6%
  - Physician & Clinical Services 4.2%
  - Retail Prescription Drug .4%
  - Other Health, Residential & Personal Care 5.6%
  - Nursing Care Facilities and CCRC's 2.0%
  - Dental Services 3.2%
  - Home Health 4.3%
  - Other Professional Services 4.6%
  - Non-Durable Medical Products 2.2%
  - Durable Medical Equipment 6.8%



** Source: National Health Care Expenditures 2017 Fact Sheet released by The CMS on 4/26/19; https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html*

Price Drives Aggregate Spending Increase*

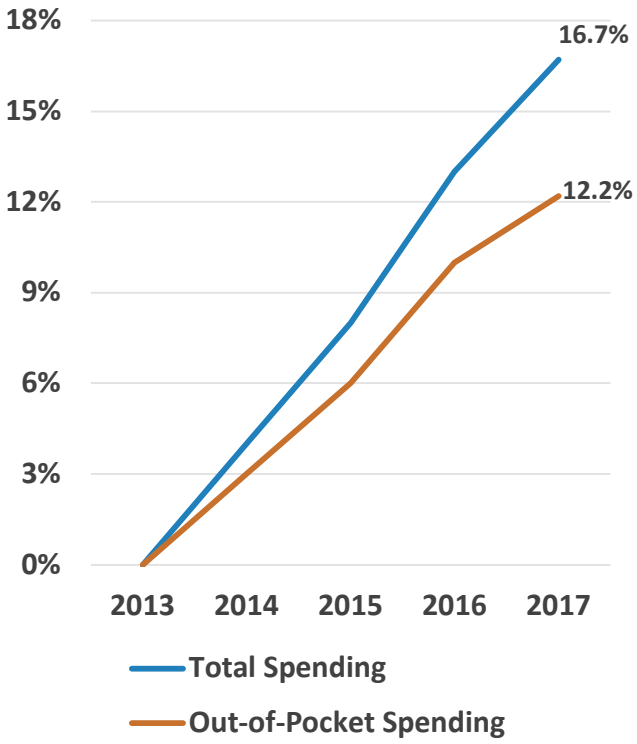




** Source: Health Care Cost Institute 2017 Annual Health Care Cost and Utilization Report; an analysis of spending, price, and utilization for individuals under 65 covered by employer-sponsored insurance (ESI). Dated February 2019*

Out-of-Pocket Spending on the Rise*

- The graphic at right depicts the cumulative increase in total spending and out-of-pocket spending for the time period of 2013-2017.
- As reflected, consumers have felt the bulk of the increase in spending over the past 5 years, bearing cumulative increases of just over 12%.
- This increase does not include the increasing costs of ESI, which according to Kaiser Family Foundation rose at a rate of 14% for single coverage and 15% for family coverage during the same time period.
- Regardless of the reason, escalation of OOP along with increasing premiums will ultimately drive consumerism in health care.



** Source: Health Care Cost Institute 2017 Annual Health Care Cost and Utilization Report; an analysis of spending, price, and utilization for individuals under 65 covered by employer-sponsored insurance (ESI). Dated February 2019*

CMS Rural Health Strategy *Objectives*

1. Apply a rural lens to CMS programs and policies
2. Improve access to care through provider engagement and support
3. Advance telehealth and telemedicine
4. Empower patients in rural communities to make decisions about their healthcare
5. Leverage partnerships to achieve the goals of the CMS Rural Health Strategy

https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf

Do any of these changes concern you? Excite you? Grab your attention? They should! These topics and many others are what CLA's newest blog, HI2, will be focusing on → the ongoing disruption and innovations in health care.

Subscribe to Blog

blogs.claconnect.com

Accounting Industry Update: New Accounting Standards

New Accounting Standards

Topic	Communication
Leases – GASB 87	1. Addresses accounting and financial reporting for leases by state and local governments. 2. The Statement establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. 3. Requires the recognition of certain right to use lease assets and related liabilities for leases that were previously classified as operating leases. 4. Effective for years beginning after December 15, 2019, with earlier applications permitted.

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PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH

FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED DECEMBER 31, 2019 AND 2018

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
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YEARS ENDED DECEMBER 31, 2019 AND 2018

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INDEPENDENT AUDITORS' REPORT

Board of Directors
Park Hospital District
dba: Estes Park Health
Estes Park, Colorado

Report on the Financial Statements

We have audited the accompanying financial statements of Park Hospital District dba: Estes Park Health (the District), which comprise the statements of net position as of December 31, 2019 and 2018, and the related statements of revenues, expenses, and changes in net position and cash flows, and the statements of financial position and related statements of activities of its discretely presented component unit Estes Park Health Foundation, for the years 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 the financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *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 auditors' 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 District'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 District'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.

Board of Directors
Park Hospital District
dba: Estes Park Health

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Park Hospital District dba: Estes Park Health and of its discretely presented component unit Estes Park Health Foundation as of December 31, 2019 and 2018, and the respective changes in net position and cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 3 through 8 and the budgeted and actual revenues and expenses on page 35 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 Board 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 our audits 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 Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated April 27, 2020, on our consideration of the District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the result of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the District's internal control over financial reporting and compliance.

CliftonLarsonAllen LLP

Denver, Colorado
April 27, 2020

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
MANAGEMENT'S DISCUSSION AND ANALYSIS
DECEMBER 31, 2019 AND 2018

INTRODUCTION

This management's discussion and analysis of Park Hospital District dba: Estes Park Health (the District) provides an overview of the District's financial activities for the years ended December 31, 2019 and 2018. It should be read in conjunction with the accompanying financial statements of the District, which begin on page 9.

USING THIS ANNUAL REPORT

The District's financial statements consist of three statements: a statement of net position, a statement of revenues, expenses, and changes in net position, and a statement of cash flows. These statements provide information about the activities of the District, including resources held by the District but restricted for specific purposes by creditors, contributors, grantors or enabling legislation. The District is accounted for as business-type activities and present their financial statements using the economic resources measurement focus and the accrual basis of accounting. The Foundation's financial statements consist of a statement of financial position and a statement of activities. The Foundation information is not included in management's discussion and analysis.

FINANCIAL HIGHLIGHTS

- The District's cash and noncurrent cash and investments decreased in 2019 by $1,460,517, or 7%, compared to a decrease of $417,587, or 2%, in 2018.
- Net position decreased $248,038 in 2019 compared to an increase of $2,548,749 in 2018.
- Net operating revenues decreased by $247,990, or 0.5%, in 2019, compared to an increase of $4,675,537, or 10%, in 2018.
- Operating expenses increased by $2,550,070, or 5%, in 2019, and $5,221,287, or 12%, in 2018.
- Nonoperating revenues (expenses) decreased by $9,240 in 2019 compared to an increase of $348,617 in 2018.

THE STATEMENT OF NET POSITION AND STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

One of the most important questions asked about any organization's finances is, "Is the organization as a whole better or worse off as a result of the year's activities?" The statement of net position and the statement of revenues, expenses, and changes in net position report information about the Districts' resources and its activities in a way that helps answer this question. These statements include all restricted and unrestricted assets and all liabilities using the accrual basis of accounting. Using the accrual basis of accounting means that all of the current year's revenues and expenses are taken into account regardless of when cash is received or paid.

THE STATEMENT OF NET POSITION AND STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION (CONTINUED)

These two statements report the District's net position and changes in it. The District's total net position—the difference between assets and liabilities—is one measure of the District's financial health or financial position. Over time, increases or decreases in the District's net position is an indicator of whether their financial health is improving or deteriorating. Other nonfinancial factors, such as changes in the District's patient base, changes in legislation and regulations, measures of the quantity and quality of services provided to its patients, and local economic factors, should also be considered to assess the overall financial health of the District.

THE STATEMENT OF CASH FLOWS

The final required statement is the statement of cash flows. The statement reports cash receipts, cash payments, and net changes in cash and cash equivalents resulting from operations, noncapital financing activities, capital and related financing activities, and investing activities. It provides answers to such questions as where did cash come from, what was cash used for, and what was the change in cash and cash equivalents during the reporting period.

THE DISTRICT'S NET POSITION

The District's net position is the difference between its assets and liabilities reported in the statements of net position. The District's net position decreased $248,038 (1%) in 2019 and increased $2,548,749 (6%) in 2018 as shown in Table 1.

TABLE 1: ASSETS, LIABILITIES, AND NET POSITION

	2019	2018	2017
ASSETS AND DEFERRED OUTFLOWS			
Cash and Cash Equivalents	$ 18,703,367	$ 13,272,797	$ 10,006,606
Patient and Resident Accounts Receivable, Net	6,455,682	6,470,014	6,294,121
Other Current Assets	6,478,394	5,799,168	5,803,693
Capital Assets, Net	31,746,460	29,628,676	30,009,464
Long-Term Investments	2,014,341	8,905,428	12,589,206
Other Noncurrent Assets	285,184	325,000	337,391
Total Assets	$ 65,683,428	$ 64,401,083	$ 65,040,481
LIABILITIES			
Current Liabilities	$ 5,948,560	$ 4,507,317	$ 6,665,665
Long-Term Liabilities	14,240,513	14,545,000	15,585,000
Total Liabilities	20,189,073	19,052,317	22,250,665
Deferred Inflows - Property Taxes	3,119,724	2,726,097	2,715,896
NET POSITION			
Net Investment in Capital Assets	18,261,460	15,083,676	13,389,544
Restricted Expendable	1,412,536	1,403,206	1,402,013
Unrestricted	22,700,635	26,135,787	25,282,363
Total Net Position	42,374,631	42,622,669	40,073,920
Total Liabilities, Deferred Inflows, and Net Positio	$ 65,683,428	$ 64,401,083	$ 65,040,481

THE DISTRICT'S ASSETS AND LIABILITIES

The most noteworthy changes in 2019 to the District's statement of net position are the increases in capital assets and current liabilities, along with decreases in total cash and investments. The statement of net position shows that total cash and investments decreased $1,460,517 between 2018 and 2019. A decline in the operating loss was the primary driver of the decrease in current cash and investments in 2019 along with an increase in capital expenditures. Net capital assets experienced an increase of $2,117,784 between 2018 and 2019 as a result of fixed asset additions in the current year being offset by continued depreciation on the assets that have been placed in service. Current liabilities increased in 2019 primarily as a result of timing of payments being made.

The most noteworthy changes in 2018 to the District's statement of net position are the increases in net patient and resident accounts receivable, along with decreases in total cash and investments, capital assets, current liabilities, and long-term debt. The statement of net position shows that total cash and investments decreased $417,587 between 2017 and 2018. A decline in operating income (loss) was the primary driver of the decrease in current cash and investments in 2018. Net patient and resident accounts receivable increased as a result of an increase in net patient and resident revenues in fiscal year 2018. Net capital assets experienced a decrease of $380,788 between 2017 and 2018 as a result of fixed asset additions in the current year being offset by continued depreciation on the assets that have been placed in service. Current liabilities decreased in 2018 primarily as a result of timing of payments being made. Long-term debt decreased in 2018 as a result of the Districts continuing to make principal payments on the outstanding long-term debt. The District made both the 2018 and the 2019 principal payments on the long-term debt during fiscal year 2018.

OPERATING RESULTS AND CHANGES IN DISTRICT'S NET POSITION

In 2019 the District's net position decreased by $248,038 while in 2018 it increased by $2,548,749. See Table 2 for the operating results and changes in net position.

OPERATING RESULTS AND CHANGES IN DISTRICT'S NET POSITION (CONTINUED)

TABLE 2: OPERATING RESULTS AND CHANGES IN NET POSITION

	2019	2018	2017
OPERATING REVENUES			
Net Patient and Resident Service Revenues	$ 48,337,074	$ 48,444,063	$ 43,578,483
Other Operating Revenues	727,677	868,678	1,058,721
Total Operating Revenues	49,064,751	49,312,741	44,637,204
OPERATING EXPENSES			
Salaries and Employee Benefits	28,516,716	26,722,743	24,946,789
Purchased Services and Professional Fees	11,797,929	10,902,501	8,459,130
Supplies and Other	9,898,447	10,050,079	8,786,721
Depreciation	2,081,218	2,068,917	2,330,313
Total Operating Expenses	52,294,310	49,744,240	44,522,953
OPERATING GAIN (LOSS)	(3,229,559)	(431,499)	114,251
NONOPERATING REVENUES AND EXPENSES			
Property Taxes	2,896,027	2,890,593	2,725,660
Investment Income	334,928	256,522	145,314
Interest Expense	(395,453)	(409,376)	(432,885)
Other Nonoperating Revenues and Expenses, Net	43,924	150,927	101,960
Net Nonoperating Revenues	2,879,426	2,888,666	2,540,049
EXCESS (DEFICIT) OF REVENUES OVER EXPENS	(350,133)	2,457,167	2,654,300
CAPITAL GRANTS	102,095	91,582	108,196
INCREASE (DECREASE) IN NET POSITION	$ (248,038)	$ 2,548,749	$ 2,762,496

OPERATING GAIN (LOSS)

The first component of the overall change in the District's net position is its operating gain (loss), which is the difference between net patient and resident service revenue and the expenses incurred to perform those services. In 2019, the District reported an operating loss of $3,229,559, which is an increase from the operating loss reporting in 2018. The District's management and staff have worked together to ensure quality patient care while keeping rates to patients competitive with other hospitals, controlling expenses, and maintaining a strong financial position through investments, tax revenues, and grants and contributions.

Net patient and resident service revenue of $48.3 million in 2019 which is consistent with 2018 net patient and resident service revenue. Salaries and employee benefits increased in 2019 by $1,793,973 or 6.3%. This was driven by salary increases and staff and physician turnover. Purchased services and professional fees increased in 2019 by $895,428 as a result of additional programs, physician contract labor needs, and recruiting challenges.

OPERATING GAIN (LOSS) (CONTINUED)

The provision for bad debt in 2019 increased from 2018 by 58%. The increase in the provision for bad debt was primarily driven by a decrease in charity care provided in 2019 and a receivables cleanup effort in anticipation of the conversion to the Epic electronic medical record system. It is important to note that the allowance for self-pay accounts receivable, inclusive of bad debt reserve, was $1,784,000 and $1,474,000 for 2019 and 2018, respectively.

Net patient and resident service revenue of $48.4 million in 2018 represented a 10% increase over 2017. The District had an increase in outpatient procedures, which contributed to the increase in net patient and resident service revenues. Salaries and employee benefits increased in 2018 by $1,775,954 or 6.6%. This was driven by salary increases and turnover in physician staffing. Purchased services and professional fees increased in 2018 by $2,443,371 as a result of additional programs and staffing recruiting challenges. Supplies and other expenses increased in 2018 by $1,263,358 or 12.6%, as a result of increased patient volumes and an increase in pain management, wound care, and chemotherapy costs.

The provision for bad debt in 2018 decreased from 2017 by 60%. The decrease in the provision for bad debt was primarily driven by an increase in charity care provided in 2018. It is important to note that the allowance for self-pay accounts receivable, inclusive of bad debt reserve, was $1,474,000 and $1,474,000 for 2018 and 2017, respectively.

The District has policies established regarding the request of an initial deposit or payment for elective services, predicated on the expectation that bad debts and long-term accounts receivable will decline, thereby receiving cash flow and lower allowances. Further, the District has a financial assistance policy in place with a basis from the federal poverty guidelines. Discounts are offered for prompt payment of self-pay receivables.

NONOPERATING REVENUES AND EXPENSES

Nonoperating revenues and expenses consist primarily of property tax revenue, investment income, and interest expense. Property tax revenues from the county increased 0.2% in 2019 and 6% in 2018. Revenues from investments increased by 23% for 2019 and 77% for 2018, due to the changing economic climate. Interest expense decreased 4% in 2019 and 6% in 2018 as a result of principal payments continuing to be made on outstanding long-term debt.

THE DISTRICTS' CASH FLOWS

The changes in the District's cash flows are consistent with changes in operating income and losses and nonoperating revenues and expenses, as discussed earlier.

CAPITAL ASSETS, NET

The District's capital assets, net of accumulated depreciation, increased from $29,628,676 in 2018 to $31,746,460 in 2019, as detailed in Note 6 to the financial statements. During 2019 and 2018, the District added capital assets of $4,199,002 and $1,707,108, respectively. Of the 2019 capital asset additions, $2,857,882 was related to the new electronic health record and accounting system implementation. This project was capitalized in the last part of fiscal year 2019.

LONG-TERM DEBT

At December 31, 2019 and 2018, the District had long-term debt (including current portion) of $13,485,000 and $14,545,000, respectively. The District did not issue any new debt during 2019. During 2018 the District did pay its capital lease obligation in full.

OTHER ECONOMIC FACTORS

The District operates in rural Colorado in Larimer County. This area is a resort destination, which generally relies on tourism. As a result, the community can be impacted by national economic and environmental trends.

CONTACTING THE DISTRICTS' FINANCIAL MANAGEMENT

This financial report is designed to provide our patients, suppliers, taxpayers, investors, and creditors with a general overview of the District's finances and to show the District's accountability for the money they receive. Questions about this report and requests for additional financial information should be directed to the District's executive office by telephoning 970-577-4470.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
STATEMENTS OF NET POSITION
DECEMBER 31, 2019 AND 2018

ASSETS	2019	2018
CURRENT ASSETS		
Cash and Cash Equivalents	$ 18,703,367	$ 13,272,797
Restricted Cash Under Debt Agreement	1,412,536	1,403,206
Receivables:		
Patient and Resident, Net of Estimated Uncollectibles of Approximately $1,784,000 in 2019 and $1,474,000 in 2018, Respectively	6,455,682	6,470,014
Property Taxes and Other	3,288,957	2,870,617
Supplies	1,096,406	1,111,852
Prepaid Expenses	680,495	413,493
Total Current Assets	31,637,443	25,541,979
LONG-TERM INVESTMENTS	2,014,341	8,905,428
CAPITAL ASSETS		
Capital Assets Not Being Depreciated	1,331,948	1,174,761
Depreciable Capital Assets, Net of Accumulated Depreciation	30,414,512	28,453,915
Total Capital Assets, Net	31,746,460	29,628,676
LONG-TERM PREPAID LEASE	285,184	325,000
Total Assets	$ 65,683,428	$ 64,401,083

See accompanying Notes to Financial Statements.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
STATEMENTS OF NET POSITION (CONTINUED)
DECEMBER 31, 2019 AND 2018

LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION	2019	2018
CURRENT LIABILITIES		
Accounts Payable	$ 2,250,218	$ 1,215,050
Estimated Third-Party Payor Settlements	829,000	869,000
Accrued Expenses:		
Salaries, Wages, and Related Liabilities	1,683,574	1,351,015
Compensated Absences	1,102,158	991,689
Other	83,610	80,563
Total Current Liabilities	5,948,560	4,507,317
LONG-TERM LIABILITIES		
Long-Term Debt	13,485,000	14,545,000
Long-Term Portion of Accounts Payable	755,513	-
Total Long-Term Liabilities	14,240,513	14,545,000
Total Liabilities	20,189,073	19,052,317
DEFERRED INFLOWS OF RESOURCES - PROPERTY TAXES	3,119,724	2,726,097
NET POSITION		
Net Investment in Capital Assets	18,261,460	15,083,676
Restricted, Expendable	1,412,536	1,403,206
Unrestricted	22,700,635	26,135,787
Total Net Position	42,374,631	42,622,669
Total Liabilities, Deferred Inflows of Resources, and Net Position	$ 65,683,428	$ 64,401,083

See accompanying Notes to Financial Statements.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
ESTES PARK HEALTH FOUNDATION
DISCRETELY PRESENTED COMPONENT UNIT
STATEMENTS OF FINANCIAL POSITION
DECEMBER 31, 2019 AND 2018

	2019	2018
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 528,911	$ 540,260
Promises to Give, Short-Term	8,002	100
Other Receivables	5,230	8,612
Prepaid Expenses	1,236	1,293
Total Current Assets	543,379	550,265
OTHER ASSETS		
Investments	3,385,094	2,610,067
Charitable Remainder Unitrust Receivable	81,131	70,396
Net Promises to Give, Long-Term	9,727	5,325
Total Other Assets	3,475,952	2,685,788
Total Assets	$ 4,019,331	$ 3,236,053
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable	$ 68	$ 298
Accrued Expenses	23,077	46,203
Total Current Liabilities	23,145	46,501
NET ASSETS		
Net Assets without Donor Restrictions	1,041,584	631,415
Net Assets with Donor Restrictions	2,954,602	2,558,137
Total Net Assets	3,996,186	3,189,552
Total Liabilities and Net Assets	$ 4,019,331	$ 3,236,053

See accompanying Notes to Financial Statements.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
YEARS ENDED DECEMBER 31, 2019 AND 2018

	2019	2018
OPERATING REVENUE		
Net Patient and Resident Service Revenue, Net of Provision for Bad Debts of approximately $1,130,000 in 2019 and $715,000 in 2018, Respectively	$ 48,337,074	$ 48,444,063
Other Revenue	727,677	868,678
Total Operating Revenue	49,064,751	49,312,741
OPERATING EXPENSES		
Salaries and Wages	22,868,648	20,941,930
Employee Benefits	5,648,068	5,780,813
Professional Fees and Purchased Services	11,797,929	10,902,501
Supplies	5,964,403	5,715,814
Utilities	583,846	550,420
Leases and Rentals	401,423	318,845
Insurance	305,411	292,015
Repairs and Maintenance	150,314	252,549
Depreciation	2,081,218	2,068,917
Other	2,493,050	2,920,436
Total Operating Expenses	52,294,310	49,744,240
OPERATING LOSS	(3,229,559)	(431,499)
NONOPERATING REVENUES (EXPENSES)		
Property Tax Revenues	2,896,027	2,890,593
Interest Expense	(395,453)	(409,376)
Investment Income	334,928	256,522
Gain (Loss) on Disposal of Capital Assets	8,500	(9,979)
Noncapital Grants and Contributions	23,021	165,241
Other	12,403	(4,335)
Total Nonoperating Revenues, Net	2,879,426	2,888,666
EXCESS (DEFICIT) OF REVENUES OVER EXPENSES BEFORE CAPITAL CONTRIBUTIONS	(350,133)	2,457,167
Capital Contributions	102,095	91,582
INCREASE (DECREASE) IN NET POSITION	(248,038)	2,548,749
Net Position - Beginning of Year	42,622,669	40,073,920
NET POSITION - END OF YEAR	$ 42,374,631	$ 42,622,669

See accompanying Notes to Financial Statements.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
ESTES PARK HEALTH FOUNDATION
DISCRETELY PRESENTED COMPONENT UNIT
STATEMENTS OF ACTIVITIES
YEARS ENDED DECEMBER 31, 2019 AND 2018

	2019	2018
REVENUES, GAINS, AND OTHER SUPPORT WITHOUT RESTRICTIONS		
Contributions	$ 134,371	$ 200,008
Investment Income (Loss), Net	263,595	(44,427)
Net Assets Released from Restriction	420,800	199,414
Total Revenues, Gains, and Other Support without Restrictions	818,766	354,995
EXPENSES		
Grants and Contributions to Estes Park Medical Center:		
Capital Assets	61,240	273,180
Salaries and Benefits	260,212	222,763
Advertising and Marketing	32,876	14,609
Office Expenses	10,146	17,168
Professional Fees	28,306	17,886
Contracted Services	5,072	18,148
Insurance	2,511	2,437
Travel and Meetings	8,234	2,767
Total Expenses	408,597	568,958
INCREASE (DECREASE) IN NET ASSETS WITHOUT DONOR RESTRICTIONS	410,169	(213,963)
NET ASSETS WITH DONOR RESTRICTIONS		
Contributions	457,704	158,481
Restricted Investment Income (Loss)	359,561	(79,328)
Net Assets Released from Restriction	(420,800)	(199,414)
Increase (Decrease) in Net Assets with Donor Restrictions	396,465	(120,261)
CHANGE IN NET ASSETS	806,634	(334,224)
Net Assets - Beginning of Year	3,189,552	3,523,776
NET ASSETS - END OF YEAR	$ 3,996,186	$ 3,189,552

See accompanying Notes to Financial Statements.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 2019 AND 2018

	2019	2018
CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts from and on Behalf of Patients and Residents	$ 48,311,406	$ 48,209,170
Payments to Suppliers and Contractors	(21,375,786)	(21,380,216)
Payments for Employee Salaries and Benefits	(28,070,641)	(27,062,979)
Other Receipts and Payments	712,187	882,099
Net Cash Provided (Used) by Operating Activities	(422,834)	648,074
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Property Taxes Supporting Operations	2,886,804	2,895,136
Noncapital Grants and Contributions	23,021	165,241
Net Cash Provided by Noncapital Financing Activities	2,909,825	3,060,377
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchase and Construction of Capital Assets	(2,940,651)	(1,776,918)
Proceeds from Disposal of Capital Assets	8,500	9,000
Principal Payments on Long-Term Debt	(1,060,000)	(2,074,920)
Interest Paid on Long-Term Debt	(395,453)	(620,052)
Capital Contributions	102,095	91,582
Net Cash Used by Capital and Related Financing Activities	(4,285,509)	(4,371,308)
CASH FLOWS FROM INVESTING ACTIVITIES		
Sales of Investments	6,891,087	3,649,586
Investment Income and Other	347,331	252,187
Net Cash Provided by Investing Activities	7,238,418	3,901,773
NET INCREASE IN CASH AND CASH EQUIVALENTS	5,439,900	3,238,916
Cash and Cash Equivalents - Beginning of Year	14,676,003	11,437,087
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 20,115,903	$ 14,676,003

See accompanying Notes to Financial Statements.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
STATEMENTS OF CASH FLOWS (CONTINUED)
YEARS ENDED DECEMBER 31, 2019 AND 2018

	2019	2018
RECONCILIATION OF CASH AND CASH EQUIVALENTS TO THE STATEMENTS OF NET POSITION		
Cash and Cash Equivalents	$ 18,703,367	$ 13,272,797
Restricted Cash Under Debt Agreement	1,412,536	1,403,206
Total Cash and Cash Equivalents	$ 20,115,903	$ 14,676,003
RECONCILIATION OF OPERATING LOSS TO NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES		
Operating Loss	$ (3,229,559)	$ (431,499)
Adjustments to Reconcile Operating Loss to Net Cash Provided (Used) by Operating Activities		
Depreciation	2,081,218	2,068,917
Provision for Bad Debts	1,130,251	714,907
(Increase) Decrease in Assets:		
Patient and Resident Receivables	(1,115,919)	(890,800)
Other Receivables	(15,490)	13,421
Supplies	15,446	(68,636)
Prepaid Expenses	(267,002)	84,706
Long-Term Prepaid Lease	39,816	-
Increase (Decrease) in Liabilities:		
Accounts Payable	532,330	(443,706)
Estimated Third-Party Payor Settlements	(40,000)	(59,000)
Accrued Salaries, Compensated Absences, and Other	446,075	(340,236)
Net Cash Provided (Used) by Operating Activities	$ (422,834)	$ 648,074
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Capital Assets Included in Accounts Payable	$ 1,258,351	$ -

See accompanying Notes to Financial Statements.

NOTE 1 NATURE OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Nature of Organization and Reporting Entities

The financial statements of Park Hospital District dba: Estes Park Health (the District) have been prepared in accordance with accounting principles generally accepted in the United States of America. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. The significant accounting and reporting policies and practices used by the District are described below.

The District operates a 23-bed acute care facility (Hospital); the Prospect Park Nursing Facility (Nursing Facility), a 52-bed skilled nursing facility; and the Physician Clinic (Clinic) located in Estes Park, Colorado. The District is organized as a political subdivision of the State of Colorado and has been recognized by the Internal Revenue Service as exempt from federal income taxes under Internal Revenue Code Section 501(a). The District is governed by a board of directors consisting of five members elected by residents of Park Hospital District. The District is not a component unit of another governmental entity.

For financial reporting purposes, the District is reported separately from the Estes Park Health Foundation (the Foundation). The Foundation is a 501(c)(3) organization whose sole purpose is to support the District and is reported as a discretely presented component unit of the District. Estes Park Health Foundation conducts fundraising campaigns on behalf of the District. The Foundation's individual financial statements can be obtained from management of the Foundation.

During fiscal year 2018 the Park Hospital District updated its trade name which it does business under from Estes Park Medical Center to Estes Park Health. The financial statements have been updated for this change.

Standards of Accounting and Financial Reporting

The accompanying financial statements have been presented in conformity with accounting principles generally accepted in the United States of America in accordance with the American Institute of Certified Public Accountants' audit and accounting guide, health care entities, and other pronouncements applicable to health care organizations and guidance from the GASB, where applicable.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

NOTE 1 NATURE OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Net Position

The net position of the District is classified in three components. *Net investment in capital assets* consist of capital assets net of accumulated depreciation and reduced by any outstanding balances of borrowings used to finance the purchase or construction of those assets. *Restricted expendable net position* is noncapital net position that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the District. Restricted net assets are reduced by any liabilities payable from restricted assets. *Unrestricted net position* is the remaining net assets that do not meet the definition of invested in capital assets net of related debt or restricted.

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less, excluding internally designated or restricted cash and investments. For the purposes of the statement of cash flows, the District considers all cash and investments with an original maturity of three months or less as cash and cash equivalents.

Patient and Resident Accounts Receivable, Net

The District reports patient and resident accounts receivable for services rendered at net realizable amounts from third-party payors, patients, residents and others. The District provides an allowance for bad debts based upon a review of outstanding receivables, historical collection information, and existing economic conditions. As a service to the patient and residents, the District bills third-party payors directly and bills the patient or resident when the patient or resident's liability is determined. Patient and residents are not required to provide collateral for services rendered. Patient and resident accounts receivable are ordinarily due in full when billed. Delinquent receivables are written off based on individual credit evaluation and specific circumstances of the patient, resident or third-party payor. In addition, an allowance is estimated for other accounts based on historical experience of the District. At December 31, 2019 and 2018, the allowance for uncollectible accounts was approximately $1,784,000 and $1,474,000, respectively.

Property Tax Receivable and Revenue

Property tax receivable is recognized on the lien date, which is January 1 of the tax year in Colorado. The property tax receivable represents taxes certified by the board of directors to be collected in the next fiscal year. However, by statute, the tax asking becomes effective on the first day of the following year. Although the property tax receivables has been recorded, the related revenue is considered a deferred inflow of resources – unavailable revenue and will not be recognized as revenue until the year for which it has been levied.

Lien date	-	January 1
Levy date	-	January 1, succeeding year
Due dates	-	February 28 and June 15, succeeding year

NOTE 1 NATURE OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Supplies

Supply inventories are stated at the lower of cost, determined using the first-in, first-out basis, or net realizable value.

Noncurrent Cash and Investments

Noncurrent cash and investments includes long-term investments, internally designated investments which are set asides by the board of directors for future capital improvements, over which the board retains control and may at its discretion subsequently use for other purposes, and cash and investments restricted by donors. Investments are measured at fair value.

Investment income includes dividend and interest income, realized gains and losses on investments carried at other than fair value and the net change for the year in the fair value of investments carried at fair value.

Capital Assets, Net

Capital asset acquisitions in excess of $5,000 are capitalized at cost at the date of acquisition or fair value at the date of donation, if acquired by gift. Depreciation is computed using the straight-line method over the estimated useful life of each asset. Assets under capital lease obligations and leasehold improvements are depreciated over the shorter of the lease term or their respective estimated useful lives. The following estimated useful lives are being used by the District:

	Years
Land Improvements	8 to 40
Buildings and Leasehold Improvements	5 to 40
Equipment	2 to 25

Gifts of long-lived assets such as land, buildings, or equipment are reported as additions to unrestricted net position, and are excluded from excess (deficit) of revenue over expenses before capital contributions. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted net positon.

Compensated Absences

The District's policies permit most employees to accumulate paid time-off benefits. Expense and the related liability are recognized as benefits when earned. Compensated absence liabilities are computed using the regular pay rates in effect at the statement of net position date.

NOTE 1 NATURE OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Estimated Health Claims Payable

The District provides for self-funded insurance reserves for estimated incurred but not reported claims for its employee health plan. These reserves, which are included in salaries, wages, and related liabilities on the statements of net position, are estimated based upon historical submission and payment data, cost trends, utilization history, and other relevant factors. Adjustments to reserves are reflected in the operating results in the period in which the change in estimate is identified.

Deferred Inflows of Resources

Although certain revenues are measurable, they are not available. Available means collected within the current period or expected to be collected soon enough thereafter to be used to pay liabilities of the current period. Deferred inflows of resources represents the amount of assets that have been recognized, but the related revenue has not been recognized since the assets are not collected within the current period or expected to be collected soon enough thereafter to be used to pay liabilities of the current period. Deferred inflows of resources consist of unavailable property taxes. The property taxes will be recognized as revenue in the year for which the taxes have been levied and become available.

Net Patient and Resident Service Revenue

Net patient and resident service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered and include estimated retroactive revenue adjustments and a provision for uncollectible accounts. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the services are rendered and such estimated amounts are revised in future periods as adjustments become known.

Charity Care

The District provides care without charge or at amounts less than its established rates to patients meeting certain criteria under its charity care policy. Because the District does not pursue collection of amounts determined to qualify as charity care, these amounts are not reported as net patient and resident service revenue. Charges excluded from revenue under the District's charity care policy were approximately $813,000 and $1,114,000 for 2019 and 2018, respectively.

Grants and Contributions

From time to time, the District receives grants and contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as nonoperating revenues. Amounts restricted to capital acquisitions are reported after excess (defit) of revenues over expenses before capital contributions.

NOTE 1 NATURE OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Operating Revenues and Expenses

The District's statements of revenues, expenses, and changes in net position distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services, the District's principal activity. Nonexchange revenues, including taxes, interest expense, grants, and contributions received for purposes other than capital asset acquisition, are reported as nonoperating revenues. Operating expenses are all expenses incurred to provide health care services.

Income Taxes

The District is organized as a political subdivision of the state of Colorado and has been recognized by the Internal Revenue Service as exempt from federal income taxes under Internal Revenue Code Section 501(a). The Foundation is exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code and a similar provision for state law. However, the Foundation is subject to federal income tax on any unrelated business taxable income.

Advertising Costs

The District expenses advertising costs as incurred.

Fair Value Measurements

To the extent available, the District's investments are recorded at fair value. GASB Statement No. 72 – *Fair Value Measurement and Application*, defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. This statement establishes a hierarchy of valuation inputs based on the extent to which inputs are observable in the marketplace. Inputs are used in applying the various valuation techniques and take in to account the assumptions that market participants use to make valuation decisions. Inputs may include price information, credit data, interest and yield curve data, and other factors specific to the financial instrument. Observable inputs reflect market data obtained from independent sources.

In contrast, unobservable inputs reflect an entity's assumptions about how market participants would value the financial instrument. Valuation techniques should maximize the use of observable inputs to the extent available. A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

NOTE 1 NATURE OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Fair Value Measurements (Continued)

In contrast, unobservable inputs reflect an entity's assumptions about how market participants would value the financial instrument. Valuation techniques should maximize the use of observable inputs to the extent available. A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used for financial instruments measured at fair value on a recurring basis:

Level 1 – Inputs that utilize quoted prices (unadjusted) in active markets for identical assets or liabilities that the District has the ability to access.

Level 2 – Inputs that include quoted prices for similar assets and liabilities in active markets and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instrument. Fair values for these instruments are estimated using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows.

Level 3 – Inputs that are unobservable inputs for the asset or liability, which are typically based on an entity's own assumptions, as there is little, if any, related market activity.

NOTE 2 TAX, SPENDING, AND DEBT LIMITATIONS

Colorado voters passed an amendment to the state constitution, Article X, Section 20, which has several limitations including revenue raising, spending abilities, and other specific requirements of state and local governments.

The District's financial activity provides the basis for calculation of limitations adjusted for allowable increases tied to inflation and local growth.

The amendment excludes enterprises from its provisions. Enterprises are defined as government-owned businesses authorized to issue revenue bonds and receive less than 10% of their annual revenue in grants from all state and local governments combined. The District is of the opinion that its operations qualify for this exclusion.

Fiscal year spending and revenue limits are determined based on the prior year's spending, adjusted for inflation and local growth. Revenue in excess of the limit must be refunded unless the voters approve retention of such revenue.

NOTE 3 NET PATIENT AND RESIDENT SERVICE REVENUE

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. These payment arrangements include the following:

Hospital and Clinic

Medicare

The District has elected the Critical Access Hospital (CAH) designation. As a Critical Access Hospital, inpatient acute care services rendered to Medicare program beneficiaries are paid on a cost-reimbursed basis and inpatient nonacute services and outpatient services are reimbursed on a cost basis. The District is reimbursed for certain services at tentative rates with final settlement determined after submission of annual cost reports by the District and audits thereof by the Medicare fiscal intermediary. The Hospital's Medicare cost reports have been audited by the Medicare fiscal intermediary through December 31, 2017. Clinical services are paid on a cost basis or fixed fee schedule.

Medicaid

Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Through October 31, 2016, inpatient nonacute services, certain outpatient services, and defined capital costs related to Medicaid beneficiaries were paid based on a cost-reimbursement methodology. The District is reimbursed for cost-reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicaid fiscal intermediary. The District's Medicaid cost reports have settled through the year ended October 31, 2016. On November 1, 2016, the Medicaid program began reimbursing inpatient nonacute services and certain outpatient services using a prospective payment methodology.

In 2012, the state of Colorado adopted a provider fee program, approved by the Centers for Medicare and Medicaid Services (CMS), under which all hospitals in the state were assessed a fee. The inpatient fee is based on a rate for managed care and nonmanaged care days for the reporting period and the outpatient fee is based on a percentage of total outpatient charges. The state of Colorado uses the fees to supplement state budget funds for the Medicaid program, which brings matching federal funds into the program, enabling the state of Colorado to fund Medicaid payments to hospitals at a higher rate than would otherwise be possible. Beginning with the state fiscal year ended June 30, 2011, funding received in excess of costs to provide these services to Medicaid and uninsured patients may be refunded. As of December 31, 2019 and 2018, the District has recorded a reserve of $350,000, for the estimated portion of funding received in excess of costs. It is reasonably possible that this estimate could materially change in the near term.

NOTE 3 NET PATIENT AND RESIDENT SERVICE REVENUE (CONTINUED)

Other

The District has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the District under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

Uninsured

The District provides healthcare services to patients who have not purchased commercial healthcare insurance coverage and do not qualify as beneficiaries of the Medicare and Medicaid programs. Based upon financial information obtained, some of these patients qualify for discounts from charges under the District's charity care policy.

Nursing Facility

Medicare

The Nursing Facility participates in the Medicare program. This federal program is administered by the Centers for Medicare and Medicaid Services (CMS). The Nursing Facility is paid under the Medicare Prospective Payment System (PPS) for residents who are Medicare Part A eligible and meet the coverage guidelines for skilled nursing facility services (SNFs). The PPS is a per diem price-based system. Annual cost reports are required to be submitted to the designated Medicare Administrative Contractor; however, they do not contain a cost settlement. CMS recently finalized the Patient Driven Payment Model (PDPM) to replace the existing Medicare reimbursement system effective October 1, 2019. Under PDPM, therapy minutes are removed as the primary basis for payment and instead uses the underlying complexity and clinical needs of a patient as a basis for reimbursement. In addition, PDPM introduces variable adjustment factors that change reimbursement rates during the resident's length of stay.

Medicaid

The Nursing Facility participates in the Medicaid program administered by the Colorado Department of Health Care Financing and Policy. The Medicaid rates are established prospectively: based on the facility's annual cost report; subject to limitations for the health care related services; administration is based on a price; and the capital component is based on the fair rental allowance system. The direct health care related services component is adjusted quarterly, based on the facility's resident acuity.

NOTE 3 NET PATIENT AND RESIDENT SERVICE REVENUE (CONTINUED)

Concentrations of gross revenue by major payor accounted for the following percentages of the District's patient and resident revenues for the years ended December 31, 2019 and 2018:

	2019	2018
Medicare	43 %	48 %
Medicaid	12	14
Other Third Party	43	35
Self Pay	2	3
Total	100 %	100 %

Laws and regulations governing the Medicare, Medicaid and other programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Net patient and resident service revenue increased approximately $617,000 and $241,000 for the years ended December 31, 2019 and 2018, respectively, due to change in the allowances previously estimated that are no longer necessary as a result of final settlements and years that are no longer likely subject to audits, review, and investigations.

The following is a reconciliation of gross patient and resident service revenue to net patient and resident service revenue for the years ending December 31, 2019 and 2018:

	2019	2018
Gross Patient and Resident Service Revenue	$ 91,195,541	$ 90,001,176
Less Charity Care	(812,791)	(1,114,125)
Total Patient and Resident Service Revenue	90,382,750	88,887,051
Contractual Adjustments		
Medicare	(23,610,172)	(22,727,395)
Medicaid	(7,661,893)	(8,351,409)
Blue Cross Blue Shield	(986,647)	(904,092)
Other	(8,656,713)	(7,745,185)
Provision for Bad Debts	(1,130,251)	(714,907)
Total Contractual Adjustments and Provision for Bad Debts	(42,045,676)	(40,442,988)
Net Patient and Resident Service Revenue	$ 48,337,074	$ 48,444,063

NOTE 4 PATIENT AND RESIDENT ACCOUNTS RECEIVABLE, NET

The District grants credit without collateral to their patients and residents, most of who are area residents and are insured under third-party payor agreements. Concentrations of patient and resident accounts receivable at December 31, 2019 and 2018 consisted of the following:

	2019	2018
Medicare	29 %	39 %
Medicaid	8	9
Other Third Party	45	34
Self Pay	18	18
Total	100 %	100 %

NOTE 5 DEPOSITS AND INVESTMENTS

Deposits

The Colorado Public Deposit Protection Act (PDPA) requires that all units of local government deposit cash in eligible public depositories. Eligibility is determined by state regulators. Amounts on deposit in excess of federal insurance levels must be collateralized. The eligible collateral is determined by PDPA. PDPA allows the institution to create a single collateral pool for all public funds. The pool is to be maintained by another institution or held in trust for all the uninsured public deposits as a group. The market value of the collateral must be at least equal to the aggregate uninsured deposits.

The State Regulatory Commissioners for bank and financial services are required by statute to monitor the naming of eligible depositories and reporting of uninsured deposits and assets maintained in collateral pools.

The District may legally invest in direct obligations of and other obligations guaranteed as to principal by the U.S. Treasury and U.S. agencies and instrumentalities and in-bank repurchase agreements. It may also invest to a limited extent in corporate bonds.

NOTE 5 DEPOSITS AND INVESTMENTS (CONTINUED)

Investments

At December 31, 2019 and 2018, the District had the following investments and maturities:

			December 31, 2019			
Type	Fair Value	Rating	Less than 1	1-5	6-10	More than 10
Certificates of Deposit	$ 757,615	NA	$ 757,615	$ -	$ -	$ -
Government Securities	1,004,877	AA+	1,004,877	-	-	-
Corporate Bonds	251,849	AA-	251,849	-	-	-
Total Investments	$ 2,014,341		$ 2,014,341	$ -	$ -	$ -

			December 31, 2018			
Type	Fair Value	Rating	Less than 1	1-5	6-10	More than 10
Certificates of Deposit	$ 1,753,568	NA	$ 1,505,339	$ 248,229	$ -	$ -
Government Securities	2,394,401	AA+	2,394,401	-	-	-
Corporate Bonds	4,757,459	A+ - AA+	4,508,283	249,176	-	-
Total Investments	$ 8,905,428		$ 8,408,023	$ 497,405	$ -	$ -

Fair Value Measurements

The District uses fair value measurements to record fair value adjustments to certain assets and liabilities and to determine fair value disclosures. For additional information on how the District measures fair value refer to Note 1 – Nature of Operations and Summary of Significant Accounting Policies. The following table presents the fair value hierarchy for the balances of the assets and liabilities of the District measured at fair value on a recurring basis as of December 31, 2019 and 2018:

	December 31, 2019			
Investment Type	Level 1	Level 2	Level 3	Total
Government Securities	$ 1,004,877	$ -	$ -	$ 1,004,877
Corporate Bonds	-	251,849	-	251,849
Total	$ 1,004,877	$ 251,849	$ -	$ 1,256,726

	December 31, 2018			
Investment Type	Level 1	Level 2	Level 3	Total
Government Securities	$ 2,394,401	$ -	$ -	$ 2,394,401
Corporate Bonds	-	4,757,459	-	4,757,459
Total	$ 2,394,401	$ 4,757,459	$ -	$ 7,151,860

NOTE 5 DEPOSITS AND INVESTMENTS (CONTINUED)

Interest Rate Risk

Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. The District's investment policy does not contain a provision that limits investment maturities as a means of managing its exposure to fair value losses arising from increasing interest rates.

Credit Risk

State Statutes limits the investments in bonds, debentures or notes of any corporation to be rated "A" or higher by nationally recognized statistical rating organizations at the time of purchase. As of December 31, 2019 and 2018, the District believes it was compliant with State Statutes with regard to credit risk. The District has no investment policy that would further limit its investment options.

Custodial Credit Risk

Custodial credit risk is the risk that in the event of the failure of the counterparty, the District will not be able to recover the value of its investment or collateral securities that are in the possession of an outside party. All of the underlying securities for the District's investments in repurchase agreements at December 31, 2019 and 2018 are held by the counterparties in other than the District's name. The District's investment policy does not address how the securities' underlying repurchase agreements are to be held.

Summary of Carrying Values

The carrying values of deposits and investments shown are included in the statements of net position as follows:

	2019	2018
Carrying Value:		
Deposits	$ 20,115,903	$ 14,676,003
Investments	2,014,341	8,905,428
Total Deposits and Investments	$ 22,130,244	$ 23,581,431

	2019	2018
Included in the Following Statements of Net Position Captions:		
Cash and Cash Equivalents	$ 18,703,367	$ 13,272,797
Restricted Cash Under Debt Agreement	1,412,536	1,403,206
Noncurrent Cash and Investments:		
Long-Term Investments	2,014,341	8,905,428
Total Deposits and Investments	$ 22,130,244	$ 23,581,431

NOTE 5 DEPOSITS AND INVESTMENTS (CONTINUED)

Investment Income

Investment income consisted of the following for the years ending December 31, 2019 and 2018:

	2019	2018
Interest Income	$ 362,010	$ 299,386
Unrealized Losses	(27,082)	(42,864)
Total	$ 334,928	$ 256,522

NOTE 6 CAPITAL ASSETS, NET

Capital asset activity for the year ended December 31, 2019 was as follows:

	2019				
	Beginning Balance	Additions	Disposals and Retirements	Transfers	Ending Balance
Land	$ 513,973	$ -	$ -	$ -	$ 513,973
Land Improvements	881,009	-	-	-	881,009
Buildings and Leasehold Improvements	39,958,325	260,220	-	-	40,218,545
Equipment	9,434,095	923,713	(80,094)	2,857,882	13,135,596
Construction in Progress	661,187	3,015,069	-	(2,857,882)	818,374
Total	51,448,589	4,199,002	(80,094)	-	55,567,497
Less: Accumulated Depreciation:					
Land Improvements	658,743	35,906	-	-	694,649
Buildings and Leasehold Improvements	14,380,399	1,251,219	-	-	15,631,618
Equipment	6,780,771	794,093	(80,094)	-	7,494,770
	21,819,913	2,081,218	(80,094)	-	23,821,037
Capital Assets, Net	$ 29,628,676	$ 2,117,784	$ -	$ -	$ 31,746,460

NOTE 6 CAPITAL ASSETS, NET (CONTINUED)

Capital asset activity for the year ended December 31, 2018 was as follows:

	2018				
	Beginning Balance	Additions	Disposals and Retirements	Transfers	Ending Balance
Land	$ 513,973	$ -	$ -	$ -	$ 513,973
Land Improvements	888,759	-	(7,750)	-	881,009
Buildings and Leasehold Improvements	40,049,633	111,516	(916,659)	713,835	39,958,325
Equipment	9,988,895	369,388	(924,188)		9,434,095
Construction in Progress	148,818	1,226,204	-	(713,835)	661,187
Total	51,590,078	1,707,108	(1,848,597)	-	51,448,589
Less: Accumulated Depreciation:					
Land Improvements	629,115	37,378	(7,750)	-	658,743
Buildings and Leasehold Improvements	14,095,557	1,201,501	(916,659)	-	14,380,399
Equipment	6,855,942	830,038	(905,209)	-	6,780,771
	21,580,614	2,068,917	(1,829,618)	-	21,819,913
Capital Assets, Net	$ 30,009,464	$ (361,809)	$ (18,979)	$ -	$ 29,628,676

Construction in progress at December 31, 2019 consists of costs the related to leasehold improvements for the Urgent Care Clinic and various other projects. The Urgent Care Clinic leasehold improvements are exected to be completed in May 2020 at an estimated cost of $2.5 million. This project the being funded through a note payable as identified in Note 11. The various other projects are expected to be completed throughout the first half of fiscal year 2020 at an estimated total cost of approximately $875,000. These various projects are being funded through operations.

NOTE 7 LINE OF CREDIT

The District has entered into a line of credit agreement with a financial institution that provides for the available borrowings of $3,000,000. The agreement matures on July 30th and currently is renewed through July 30, 2020. Borrowings under the line of credit bear interest at the Prime Rate as published by the Wall Street Journal less 0.75 percentage points. The minimum interest rate is 3.5% and the line of credit is secured by all accounts the District holds with the financial institution, to the extent permitted by applicable law. There was no amount outstanding as of December 31, 2019 and 2018.

NOTE 8 LONG-TERM DEBT

The following is a summary of long-term debt transactions for the District for the years ended December 31, 2019 and 2018:

	2019				
	Beginning Balance	Additions	Reductions	Ending Balance	Amounts Due Within One Year
Promissory Notes, Series 2016	$ 14,545,000	$ -	$ (1,060,000)	$ 13,485,000	$ -

	2018				
	Beginning Balance	Additions	Reductions	Ending Balance	Amounts Due Within One Year
Promissory Notes, Series 2016	$ 16,605,000	$ -	$ (2,060,000)	$ 14,545,000	$ -
Capital Lease Obligations	14,920	-	(14,920)	-	-
Total Long-Term Debt	$ 16,619,920	$ -	$ (2,074,920)	$ 14,545,000	$ -

During 2016, the District refinanced its Limited Tax-Revenue Bonds Series 2006 (the Bonds) with Promissory Notes, Series 2016 (the Notes). The District used the proceeds from the Notes of $17,625,000 and deposits restricted under the 2006 bond indenture to complete the refinancing. The Notes bear interest of 1.85% and 2.90% with the interest being payable semiannually on each January 1 and July 1 and principal being due in varying annual installments through December 31, 2031.The Notes are secured by the District's pledged revenues. As of December 31, 2019 and 2018, the District had made the principal payment due on January 1st of the subsequent year, thus there is no current portion of long-term debt shown in the financial statements.

Restrictive Covenants

Under the terms of the Promissory Notes, Series 2016 agreement, the District is required to maintain certain deposits with the lender. Such deposits are included in restricted cash under debt agreement on the statements of net position. The Promissory Notes agreement also requires that the District satisfy certain measures of financial performance including maintaining a debt-service coverage ratio of at least 1.25, have 90 days of cash on hand, and places restrictions on incurrence of additional debt. Management believes the District is in compliance with restrictive covenants at December 31, 2019.

NOTE 8 LONG-TERM DEBT (CONTINUED)

Scheduled principal and interest payments on bank loans are as follows:

	Promissory Notes, Series 2016	
Year Ending December 31,	Principal	Interest
2020	$ -	$ 327,417
2021	1,085,000	349,304
2022	1,105,000	328,767
2023	1,125,000	307,854
2024	1,140,000	282,219
2025 - 2029	6,250,000	880,523
2030-2031	2,780,000	82,663
Total	$ 13,485,000	$ 2,558,747

Capital Lease Obligations

The District was obligated under lease agreements for equipment that was accounted for as a capital lease obligations. The capital lease obligations required varying monthly payments at an interest rate of 3% through January 2018 and were secured by the leased equipment. The capital lease obligations were paid in full during fiscal year 2018.

NOTE 9 PENSION PLAN

The District has a money purchase pension plan (the Plan) covering all employees of the District immediately upon hire. The Plan was established by and can be amended by the authority of the District's board of directors. Employee contributions to the Plan vest immediately. Employer contributions to the plan are currently set at 6.25% of eligible employee compensation. The employer contributions vest based on the following schedule: 25% based on less than a year of employment, 50% at one year of employment, 75% at two years of employment, and 100% at three or more years of employment. Distributions can be made by the participant from their vested account balance upon the participant reaching the age of 62 or terminating employment with the District. Total pension expense for the years ended December 31, 2019, 2018, and2017 was $1,480,807, $1,349,522, and $1,259,799, respectively.

NOTE 10 COMMITMENTS AND CONTINGENCIES

Risk Management

The District is exposed to various risks of loss from torts; theft of, damage to and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters other than employee health and workers' compensation claims. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

NOTE 10 COMMITMENTS AND CONTINGENCIES

Litigation

In the normal course of business, the District is, from time to time, subject to allegations that may or do result in litigation. The District evaluates such allegations by conducting investigations to determine the validity of each potential claim. Based upon the advice of legal counsel, management records an estimate of the amount of ultimate expected losses, which are not covered by insurance, if any. Events could occur that would cause the estimate of ultimate loss to differ materially in the near term.

Malpractice Claims

The District pays fixed premiums for annual medical malpractice insurance coverage under a claims-made policy. The medical malpractice insurance coverage is subject to a $1 million per claim limit and an annual aggregate limit of $3 million. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term, but reported subsequently, would be uninsured. The District is not aware of any unasserted claims, unreported incidents or claims outstanding, which are expected to exceed malpractice insurance coverage limits as of December 31, 2019. Further, the District is subject to the provisions of the Colorado Government Immunity Act, which provides a limitation on the liability of the District. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Employee Health Insurance

Substantially all of the District's employees and their dependents are eligible to participate in the District's employee health insurance plan. The District is partially self-insured for health claims of participating employees and dependents up to an annual aggregate amount of $75,000 per claim. Commercial stop-loss insurance coverage is purchased for claims in excess of the aggregate annual amount. A provision is accrued for self-insured employee health claims including both claims reported and claims incurred but not yet reported. The accrual is estimated based on consideration of prior claims experience, recently settled claims, frequency of claims, and other economic and social factors. It is reasonably possible that the District's estimate will change by a material amount in the near term.

Activity in the District's accrued employee health claims liability during 2019 and 2018 is summarized as follows:

	2019	2018
Balance - Beginning of Year	$ 319,000	$ 475,000
Current Year Claims Incurred and Changes in Estimate for Claims Incurred in Prior Years	3,410,908	3,607,957
Claims and Expenses Paid	(3,429,908)	(3,763,957)
Balance - End of Year	$ 300,000	$ 319,000

NOTE 10 COMMITMENTS AND CONTINGENCIES (CONTINUED)

Operating Leases

During fiscal year 2019 the District entered into a lease for the Urgent Care Clinic space. The lease starts in fiscal year 2020 and expires in fiscal year 2030 with an option to extend for an additional ten year period. A summary of future minimum operating lease payments are as follows:

Year Ending December 31,	
2020	$ 409,638
2021	417,831
2022	426,187
2023	434,711
2024	443,405
Thereafter	2,353,649
Total	$ 4,485,422

Compliance

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Recently, federal government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously, billed and collected revenues from patient services. The District operates a Compliance Committee which reviews the operations of the District. The District records allowances where the government has shown a pattern of adjusting periodic reports submitted by the District, including Medicare cost reports or tax reporting, or where internal reviews indicate the possibility of future adjustments. Management believes that the District is in substantial compliance with current laws and regulations.

Other

In the normal course of business, there could be various outstanding contingent liabilities such as, but not limited to, the following:

- Lawsuits alleging negligence of care
- Environmental pollution
- Violation of a regulatory body's rules and regulations
- Violation of federal and/or state laws

No other contingent liabilities such as, but not limited to those described above, are reflected in the accompanying financial statements. No such liabilities have been asserted and, therefore, no estimate of loss, if any, is determinable.

NOTE 11 SUBSEQUENT EVENTS

Subsequent to year-end, the World Health Organization declared the spread of Coronavirus Disease (COVID-19) a worldwide pandemic. The COVID-19 pandemic is having significant effects on global markets, supply chains, businesses, and communities. Specific to the District, COVID-19 may impact various parts of its 2020 operations and financial results including but not limited to additional costs for emergency preparedness, disease control and containment, potential shortages of healthcare personnel, or loss of revenue due to reductions in certain revenue streams. Management believes the District is taking appropriate actions to mitigate the negative impact. However, the full impact of COVID-19 is unknown and cannot be reasonably estimated as of December 31, 2019.

In April 2020, the District received payments under the Medicare Accelerated and Advanced Payment Program (the Program) of approximately $4,400,000 to help with cash flow during the COVID-19 pandemic. Under the Progam these funds will start to be repaid 120 days after the funding is received and are to be repaid in full within a one year from the receipt of the accelerated payments. The District also received $702,000 under the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act) which is treated as a grant.

On March 30, 2020, the District entered into a promissory note payable with a financial institution for $2,500,000 to fund the construction costs related to the Urgent Care Clinic buildout. Starting April 30, 2021, monthly payments of $22,361 are due on the promissory note payable and they continue through March 30, 2031. Interest accrues at the Bank of Colorado Estes Park 12-month Public Funds Certificate of Deposit Rate plus one percent (1.1% as of the loan issuance date). The promissory note payable is secured by a certificate of deposit account held by the financial institution.

PARK HOSPITAL DISTRICT
DBA: ESTES PARK HEALTH
BUDGETED AND ACTUAL REVENUES AND EXPENSES
YEAR ENDED DECEMBER 31, 2019
(SEE INDEPENDENT AUDITORS' REPORT)

	Actual	Budgeted	Favorable (Unfavorable) Variance
OPERATING REVENUES			
Net Patient and Resident Service Revenue	$ 48,337,074	$ 50,327,968	$ (1,990,894)
Other Revenue	727,677	875,430	(147,753)
Total Operating Revenues	49,064,751	51,203,398	(2,138,647)
OPERATING EXPENSES			
Salaries, Wages, and Employee Benefits	28,516,716	28,886,598	369,882
Other	23,777,594	22,261,824	(1,515,770)
Total Operating Expenses	52,294,310	51,148,422	(1,145,888)
OPERATING INCOME (LOSS)	(3,229,559)	54,976	(3,284,535)
NONOPERATING REVENUES (EXPENSES)	2,879,426	2,506,823	372,603
EXCESS (DEFICIT) OF REVENUES OVER EXPEN	$ (350,133)	$ 2,561,799	$ (2,911,932)

NOTE TO SCHEDULE

Annual budgets are adopted as required by Colorado statutes. Formal budgetary integration is employed as a management control device during the year. Budgets are adopted on a basis that is consistent with accounting principles generally accepted in the United States of America.

Appropriations are adopted by resolution in total.

CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Board of Directors
Park Hospital District
dba: Estes Park Health
Estes Park, Colorado

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Park Hospital District dba: Estes Park Health (the District), which comprise the statement of net position as of December 31, 2019, and the related statement of revenues, expenses, and changes in net position, and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated April 27, 2020.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the District's internal control over financial reporting (internal control) to determine the 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. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. 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.

Board of Directors
Park Hospital District
dba: Estes Park Health

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the District's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the result of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

CliftonLarsonAllen LLP

Denver, Colorado
April 27, 2020

ESTES PARK HEALTH

EPH COVID-19 Pandemic Update

April 27, 2020

OPEN FOR BUSINESS: For many weeks, Estes Park Health has been thoroughly planning for the many possible scenarios related to the Coronavirus pandemic. It's important for our community to know that, **despite all the challenges, we are open for business.** Our Physician Clinic is rocketing forward with telehealth options for our community patients, we are investigating options for other types of outpatient visits through telehealth, our lab is open, our radiology suite is open, our rehab services are available, our wound clinic and coumadin clinic and infusion clinic, open and ready to help our community. Our Community Paramedic program launches later this week and provides exceptional opportunities to the community for frontline care in their home.

COVID HOTLINE REMAINS OPEN: If you have general questions about COVID-19, or want to ask what to do about potential exposure or symptoms, or other questions for EPH – call us, 24/7, at our COVID hotline at 970-577-4400. We're here to help.

TRANSFER TO THE AVAILABLE ICUs: The great and proactive work in Colorado and Larimer County has helped slow the growth of COVID in Larimer County. As you can see from the eph.org website, in the COVID link for Larimer County, the county has 237 current cases (as of April 18, 2020) and that has grown from 122 cases as of April 1, 2020. In other words, the curve has been very well-managed. What this means is that there are Front Range ICU beds available for COVID-19 cases. What this means to EPH is that our strategy can continue to be identify, stabilize, protect – and transfer to those Front Range facilities who are most capable of providing ICU service.

CONTINUE TO SCREEN FROM HOME: One of the best safety measures you can take for all, if you are concerned that you may have COVID-19 symptoms, or that you might have been exposed, is to be screened over the phone (meaning "asked the key questions about symptoms and exposure to COVID-19"), from the safety of the home.

EPH COVID STATUS: On April 17, EPH was notified that a staff member, who had followed all proper protective protocol, had tested positive for COVID-19. Testing commenced for other members of that individual's department, and all of those other individuals tested negative. It's almost certain that this individual staff member contracted the virus outside the bounds of EPH. Per Larimer County and the CDC, our use of personal protective equipment (PPE) and other factors indicated that there is no need to test others, including patients at the hospital, unless an individual exhibits symptoms or has contact with a COVID-19 positive person.

STILL PLANNING FOR A SURGE: Despite our plan to transfer COVID-19 patients to the Front Range while beds are available, **we have still been very busy creating an environment that maximizes our ability to keep patients here IF there are no Front Range ICU rooms remaining.** We have created negative-pressure rooms in recent week, retrofitting our surgical suite rooms and one of our inpatient pods of four rooms, to provide the proper environment to keep such a patient. We have the Personal Protective Equipment available for a certain number of patients – IF the worst happens up and down the Front Range, and here in Estes. We have also analyzed the whole building for additional options, made a variety of other changes to support the situation if it progresses, and we regularly walk through the processes to ensure we're ready at a moment's notice to get in gear if we do have a case or cases.

HEALTH OF HEALTHCARE WORKERS: Our greatest concern is always our patients' well-being. But **our greatest internal concern is the health of our doctors, nurses, lab techs, pharmacists, surgery staff, radiology staff, and all the others who occupy the frontline at EPH** and are therefore potentially subject to the greatest risk of exposure. All of the actions above, in addition to their other value and purpose, are also targeted to support the health of our healthcare workers and best equip us for the challenging times ahead.

Item 6.6

ESTES PARK
HEALTH

COMMUNITY PARAMEDIC PROGRAM

Estes Park Health Paramedics Director: Guy Beesley

Community Paramedic Program Coordinator: Sharon Lowry-Bielmaier

Medical Director: Dr. Scott Chew

Table of Contents

ESTES PARK
HEALTH

Estes Park Health

Community Paramedic Program

BUSINESS PLAN

REVISED: October 2019

Estes Park Health Community Paramedic Program
Business Plan

Executive Summary

Vision: The right care delivered in the right place.

- ***What is the Community Paramedic Program?***
    - The program is designed (1) to ensure patients, especially those who don't seek care in a conventional medical practice/hospital based model for whatever reason, have access to health services and community resources; and (2) if appropriate and in compliance with Medicare and Colorado state guidelines, to have the option of providing unscheduled (911 calls) transport to alternative, non-hospital based destinations such as a physician clinic or urgent care center.
- ***How does the Community Paramedic Program (CPP) fit Estes Park Health's (EPH) mission?***
    - By reaching out to those who need care but are unwilling or unable to go to a doctor's office to obtain it and by ensuring a patient calling 911 gets the appropriate level of care, community paramedics will be able to monitor and treat patients in their homes, as needed. This in turn will reduce the risk that a patient's condition left untreated will develop into an emergent situation. By providing transportation to an alternative care site for conditions that do not need the full services of an emergency department, the patient will receive the appropriate care at a lower price, in a less stressful environment for the patient than a hospital.
- ***Key Objectives:***
    - Reduce 30-day hospital readmissions for Estes Valley residents.
    - Provide access to care and resources for residents and visitors who do not want to obtain care in a medical care provider's office or a hospital or is unable to get to his/her provider's facility, as well as to provide an option for assistance to financially

insecure residents of the Estes Valley. The first year's operational target is 100 in-home visits.

- Provide directed follow-up care and assessments to patients at the direction of physician or other medical care professional's referrals. Referrals for care and/or assessment may also come from EPH's Home Health and Hospice service providers to assist with care outside their service guidelines.

- ***Financial Considerations:***
  - Community paramedics currently work as part of EPH's EMS department and will continue to do so until EPH's planned Urgent Care Center opens. When the Urgent Care Center opens, community paramedics will assist in staffing that facility while the Community Paramedic Program (CPP) ramps up. This will allow for full utilization of the community paramedics' skills until a determination of demand has been assessed.
  - The estimated first year operational income is approximately $20,000 ($200/call, 100 calls/1st year) but this may increase based on program utilization by EPH's physicians and education of the community on the services available.

Estes Park Health Community Paramedic Program
Business Plan

The Plan

- ***PLAN MODEL***
  - The EPH Community Paramedic Program (CPP) will address the healthcare needs of the Estes Valley community in conjunction with the care provided by EPH's 911 traditional ambulance service so as to encourage the appropriate utilization of emergency medical services, increase the efficiency in EPH's EMS system, and provide person-centered care at the most appropriate level, in the most appropriate place.
  - The Estes Valley is a service area defined as including the Park Hospital District, Estes Valley Fire Protection District, the Glen Haven Area Volunteer Fire Department, Rocky Mountain National Park east of the continental divide, the Pinewood Springs Fire Protection District, the Volunteer Fire Department of Big Elk, and the Allenspark Fire Department.
  - The traditional role for EMS is to treat a patient with an emergent condition, stabilize the patient, and then transport the patient to an emergency department. See Figure 1.
  - The basis of community paramedicine is to take care of patients through direct medical care in a patient's home as well as through health education and disease prevention activities. The EPH plan will begin with (1) providing in-home care to patients based on referrals to the program from the EPH Physician Clinic, Home Health Services, and Hospice Care, and potentially from the Salud Clinic and the Timberline Clinic as well; and then (2) as needed, expanding to provide transportation to non-emergency department alternative sites including the EPH Urgent Care Center, Salud Clinic, and Timberline Clinic for conditions that do not require emergency department level care. See Figure 2.

Figure 1: Current Ambulance Service

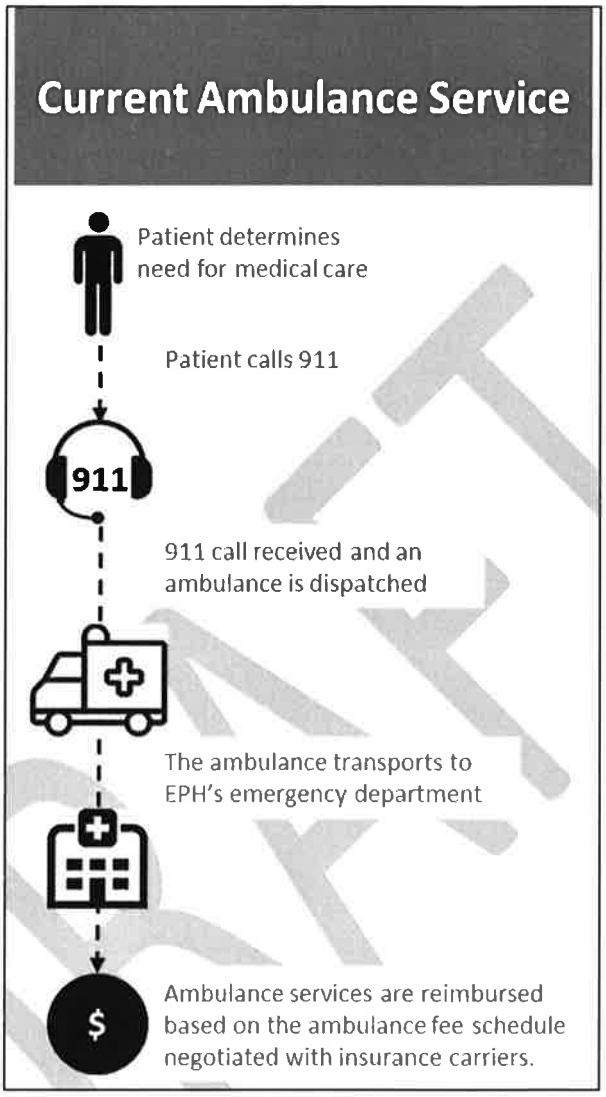


Figure 2: Community Paramedic Program

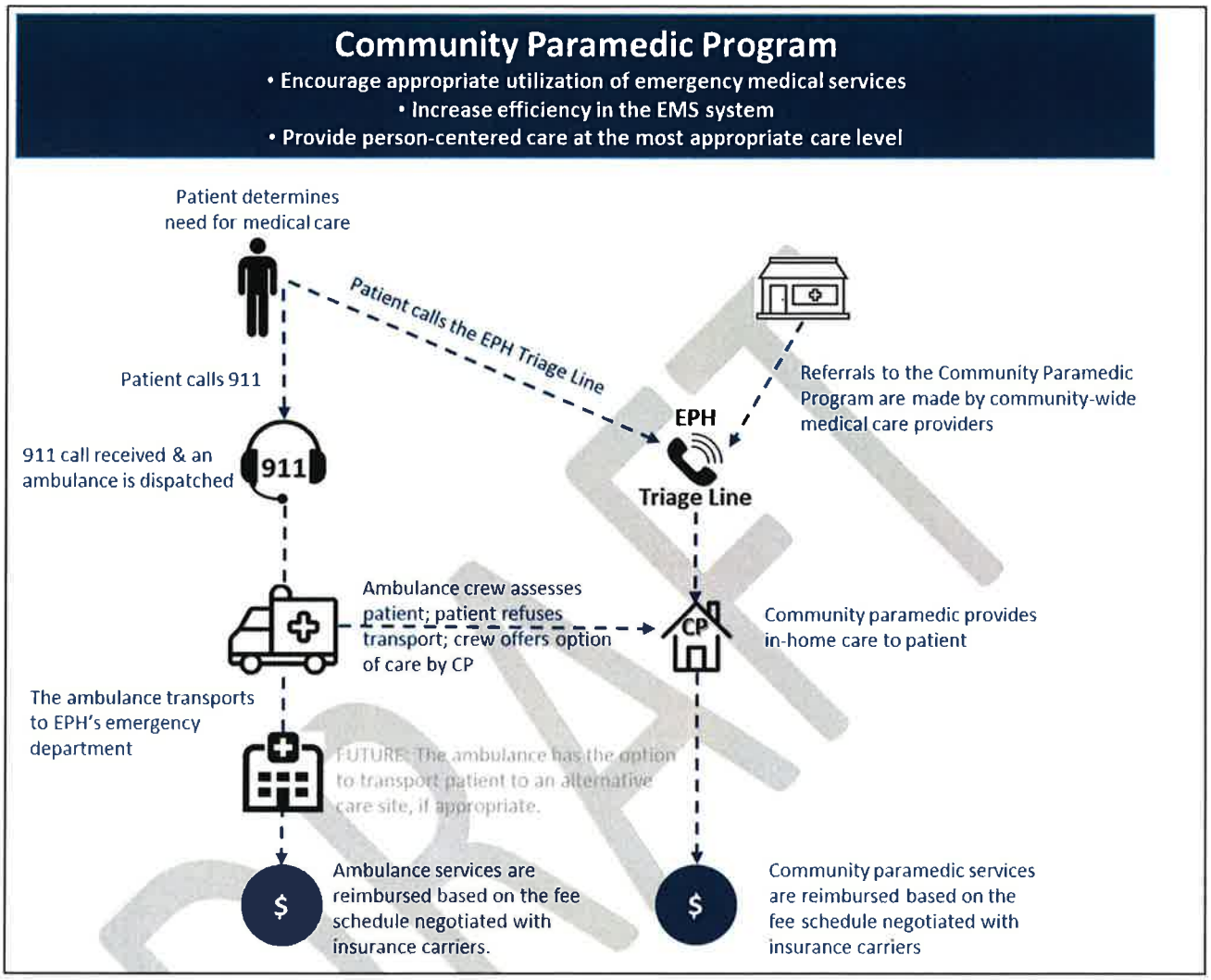


Figure 2

- The Community Paramedic Program will provide medically appropriate in-home assessment and treatment services for residents and visitors. In-home care will include but is not limited to:
    - Follow-up care for recently hospitalized patients. This may include:
        - Education of a patient and the patient's caregiver(s) on appropriate care management.

        - Screening of a patient's living situation to determine if any additional resources are needed and then helping the patient or the patient's caregivers in accessing those resources.
        - Helping the patient or the patient's caregivers in the navigation of the healthcare system including coordination of care.
        - Providing treatment within the community paramedic's scope of practice.
    - In-home assessment, safety inspections, medication reconciliation, and referral services for patients with chronic diseases, seniors, disabled patients, or patients with other specialized needs.
    - Wellness checks
    - Immunizations
    - INR (International Normalized Ratio) checks for blood anti-coagulation levels
    - Providing assessment, care, and treatment according to primary care physician referrals and visit follow-ups as generated by primary care providers or the EPH Triage nurse line.
    - Working with EPH Hospice Care to reduce the possibility of the patient or the patient's family revoking care so the patient can go to the emergency department. The community paramedic can work with the patient, family or caregivers, and hospice staff to provide treatment in the home environment.
    - Assisting EPH's Home Health Services when a patient needs care that does not meet the criteria for the provision of care by Home Health Services.
- By partnering with the Rural Estes Alliance for Community Health (REACH) and its initiative to promote mental health care, the Community Paramedic Program will collaborate with law enforcement and mental/behavioral health resources to provide

in-home assessments of patients, assistance with procuring the appropriate care and resources for the patient, and supporting rehab efforts through the Medication Assisted Therapy (MAT) program currently under development.

- Community paramedics will be potentially be able to coordinate transport to an urgent care or primary care facility for non-life threatening illnesses or conditions or simple orthopedic injuries, if appropriate, at a patient's request. This is dependent on the passage of a proposed law currently in the Colorado State Legislature.
- Proposed Alternative Destination Sites for Transport of Non-emergent Patients:
    - All patients will be cared for and attended by an appropriately certified care provider from initial patient contact through transport to an alternative care destination or in-home care. The appropriate destination will be determined through protocol and/or real-time medical control contact for direction. If transport is required, all patients will be transported by a licensed ambulance using existing transport protocols to ensure safety.
    - Salud Clinic:
        - Salud is a Federally Qualified Health Center that provides medical, dental, pharmacy and behavioral health care services to low-income, medically under-served populations in the Estes Valley. Salud can provide family medicine and pediatric services, preventative care, chronic illness management, and lab, imaging, and ultrasound services.
        - Hours of Operation:
            - Medical, Lab, Imaging, & Pharmacy: M, Tu, W, F 7:30 am - 5:00 pm; Th 7:30 am - 8:00 pm
            - Dental: M, Tu, W, Th, F 8:00 am - 5:00 pm
    - Timberline Clinic:
        - Timberline Clinic provides urgent care services during normal business hours M-F as well as providing primary care services to

many in the community. The Timberline Clinic provides general health care services including preventative care, management of chronic diseases, geriatric services, immunizations, and allergy injections as well as routine exams and testing.

- Hours of Operation:
  - Medical: M, Tu, W, Th, F 8:00 am – 6:00pm; Sa 8:00 am – 1200 pm

- Estes Park Health Urgent Care:
  - EPH Urgent Care is currently under construction with an anticipated opening by April 30, 2020. The facility will provide general care services, vaccinations and immunizations, basic diagnostic imaging and lab work.
  - Hours of Operation:
    - Medical, Lab, & Imaging: M, Tu, W, Th, F 7:30 am - 5:00 pm; Sa 7:30am - 8:00 pm

- ***PROTOCOLS AND MEDICAL CONTROL***
  - Community Paramedics will have 24/7, immediate access to medical direction consultation from both pediatric and adult providers at Estes Park Health. The Estes Valley is a rural community and the only 24/7 destination available is EPH's emergency room when other healthcare sites are closed. The ability to have in-home triage or care by community paramedics for non-emergent care will enable the provision of "after hours" care that is not currently available in the Estes Valley's current healthcare system, in addition to care provided during normal business hours.
    - HIPAA compliant modalities will be used to contact medical control 24/7 and/or partner alternative site destinations. The modalities include phone, TigerConnect for texting, and Zix for email.
  - Protocols that will be used include:

- Colorado State Community Paramedicine Toolkit
- Denver Health Protocols
- Estes Park Health Protocols

- ***COMMUNITY INFORMATION***
  - Identified health risks in the community at large:
    - Heart disease and stroke
    - Diabetes
    - Mental health
    - Respiratory/lung disease
    - Cancer
    - Homebound residents unable to obtain immunizations
    - Wound care
    - Chronic disease management
  - Residents:

    Approximately 8,500 residents live in the Estes Valley year-round, with this number swelling to approximately 12,000 in the summer months. The median age in the Estes Valley is 56 years old, making Estes Park the "oldest" community in Colorado. Frequently, the senior patient population does not seek medical care or care follow-up due to lack of transportation, poor health literacy, or a fiercely independent spirit.
  - Visitors:

    Estes Park is located at the entrance to Rocky Mountain National Park. During the summer, approximately 26,000 people per day will pass through Estes Park; approximately 6,400 per day in the winter. Altitude in the area ranges from 7500 to 12,000 feet. At elevation, many illnesses and healthcare needs are exacerbated for

residents and especially for visitors. Many patients with non-life threatening illnesses can be treated in a non-hospital facility.

- Residents with financial constraints or insurance coverage issues:

  The Estes Valley has a community of people who might not seek medical care due to financial constraints or insurance coverage issues. This community includes residents as well as transient residents working in the area on a short-term basis. Through clinics and referrals, community paramedics can provide in-home care or EPH resources to assist patients in getting appropriate care and in enrolling in available health financial resources, if needed.

- ***BENEFITS OF THE PROGRAM***
  - Provides EPH patients an option for in-home care.
  - Improved monitoring of patients under a physician's care.
  - Ability to assess a patient in his or her home environment. This allows better assessment of patient's ability to self-care, activities of daily living, medication reconciliations.
  - A feeling of security for patients from being seen in their own home, which generally can lead to better health management.
  - Ability to provide care to patients that otherwise would not seek it.
  - Patients will be provided the resources and education to manage their healthcare.
  - Initially, because the community paramedics will be also working at the Urgent Care Clinic or with the ambulance service, there will be no incremental staffing costs to EPH.

- ***RISKS OF THE PROGRAM***
  - Salud Clinic and Timberline Clinic refuse to engage in the Community Paramedic Program, which would reduce the number of care referrals to the CPP.
  - Triage, especially after hours, may need staffing support.
  - Call volume ramps up faster than expected and staffing is not adequate.
  - The Estes Valley community does not engage in the model and continues to want transport only to an emergency department.
  - Not all insurance carriers may agree to reimburse for services provided.

- ***IF THE PROGRAM IS NOT IMPLEMENTED***
  - No program in place to deliver the right care to patients in the right location whether that be the patient's home or an urgent or primary care facility.
  - Over-utilization of emergency department for conditions that could be treated in the home.
  - Utilization of emergency department for conditions that had they been managed and monitored in the home might not have resulted in the need for a visit to the emergency department.
  - Lack of alignment with national standards of care, especially Medicare and Medicaid standards, which are encouraging implementation of Medicare's Emergency Triage, Treat, and Transport program.
  - Loss of a tool to reduce readmissions.

- ***TRIAGE***
  - Triage will be handled according to the existing EPH protocols with the addition of having patients being able to be seen by a community paramedic;
    - M-F 0800 – 1700: triage is staffed by a nurse in EPH's Physician Clinic
    - All other times: the triage line is rolled to the Emergency Department and calls are handled by nurses in the Emergency Department

- ***QUALITY CONTROL AND STATE REPORTING***
  - Since the Community Paramedic Program is part of EPH EMS, all current EPH protocols for quality control, data monitoring, and reporting will be in effect.
  - Proposed metrics:
    - 30 day readmission rate for EPH patients TBD
    - Service Level Agreement (SLA) for non-emergent request for service: average response time from time of dispatch to arrival at location <=60 minutes
    - # referrals/week from EPH medical providers, Home Health, and/or Hospice >= 2

- ***KEY MILESTONES:***
  - 9/30/19 – letters of intent to operate sent to Salud Clinic and Timberline Clinic – done
  - 9/330/19 – letters of intent to operate sent to the Boards of County Commissioners of Larimer and Boulder counties, respectively - done
  - 10/5/19 – application submitted for Medicare ET3 program - done
  - 10/18/19 – application submitted for a Community Paramedic Program License under Colorado's Integrated Healthcare System.
  - Ongoing – Community paramedics to spend clinical time with the physicians in the EPH Physician's Clinic to develop a rapport with the physicians and their patients.
  - 10/15/19 – protocols to be utilized by the Triage Team reviewed by Quality and Medical Control
  - 10/22/19 – protocols to be utilized by ambulance crews written and submitted to Quality and Medical Control for review
  - 11/22/19 – all protocols due back to the Community Paramedic Program Team

- 11/30/19 – re-negotiation of intergovernmental agreements (IGAs) completed with fire departments/districts in the ambulance service area (Glen Haven Area Fire Protection District, Pinewood Springs Fire Protection District, Volunteer Fire Department of Big Elk, Allenspark Fire Protection District, and the Estes Valley Fire Protection District)
- 11/30/19 – Memorandums of Understanding (MOU) in place with Salud Clinic and Timberline Clinic - MOUs will be established with these partners in order to ensure our program's ability to utilize them as alternative destination sites. There will be no financial charges to a partner for transport to the partner's site.
- 12/01/19 – Begin trial in-home visits coordinated with and monitored by physicians from EPH's Physician Clinic
- 12/01/19 – any changes and revisions resubmitted to Quality and Medical Control for Review
- 12/31/19 – all protocols implemented
- 12/31/19 – all brochures, forms, and information packets completed and printed
- 12/31/19 – capability for taking payments via internet connectivity active; protocol for accounting and transporting cash developed and in-place
- 12/31/19 – all equipment in place; staff outfitted with uniforms
- 1Q2020 – schedule and deliver educational talks to community organizations
- 1/15/20 – receive Colorado Integrated Health Care Services (CIHCS) license for operation (estimated 90 days after submission)
- 1/15/20 (or as soon after licensing from CIHCS has been received) – Community paramedics will begin a "soft start" with EPH Physicians Clinic referrals to trial patient care in in-home settings
- 6/30/2020 – all contracts with EPH insurance carriers have been re-negotiated to include fee schedules for in-home appointments and transport to alternative care sites

Estes Park Health Community Paramedic Program

Business Plan

Market Analysis

- ***TARGETED PATIENTS***
  - Residents, visitors, or transient workers without access to transportation
  - Financial insecure patients or patients with insurance challenges
  - Post-operative patients needing follow-up care
  - Wound care
  - Patients requiring monitoring of chronic conditions
  - Immuno-compromised patients needing care or immunizations
  - Mental health patients - In Larimer County, over 10% of the population has frequent mental distress. With minimal mental health resources available in the Estes Valley, the ability to assess mental health needs in an in-home environment to determine the proper location for down valley care will help reduce the number of ED visits.
  - Elderly patients needing or preferring in-home care, follow-up care, or assessment
  - Patients needing in-home assessments for safety, physical health, mental health, activities of daily living, etc.
  - Patients needing medication reconciliation in an in-home, familiar setting
  - Dementia or mental health patients who need care but are unable to leave their homes for whatever reason
  - Potential patients participating in a MAT (Medication Assisted Therapy) program
  - "High-users" of the emergency department for primary care

- ***PROMOTION & MARKETING***
  - Community education will be provided to our alternative site partners as well as patients regarding the services that will be available to them. This will include talks and meetings with community organizations, religious groups, senior organizations and at other community meetings. There will be an emphasis that transport to alternative destinations is only for unscheduled emergency care needs and the service provided is not free. A patient's insurance will be billed at standard rates for the service. The community paramedics will be working with providers and patients on education about alternative, less expensive transport services rather than the use of ambulances.
  - Press releases will be provided to the two local newspapers.
  - Brochures will be distributed at local clinics, the hospital, distribution in the partners' offices, hotels, senior centers, community centers, etc.
  - Web based information will be available on Estes Park Health's website and social media sites. This information will be made available to our alternative destination partners to place on their websites and social media sites, respectively.
  - Visit Estes Park promotion
  - Presentations at service organizations, religious organizations, senior programs, programs at the Estes Valley Library and at the Senior Center, programs at the Community Center, and others as identified.
  - Tables at local health fairs.
  - Estes Park Health and its practitioners are included in our current plan for "roll-out" of this program. We have already contacted and performed clinical education sessions with our on campus Family Practice Physicians, Internal Medicine Physicians, FNP's, PA's and ED Physicians and these in term have begun educating their patients in the clinical setting. We will continue these education clinical sessions throughout the life of this program.

- Work with REACH to engage other medical practitioners and organizations in the Estes Valley

- ***PROJECTED VOLUME***
  - First year in-home visits: 100
    - Sources: referrals by physicians, surgeons, and other medical care providers and organizations
  - Transports to alternative sites:
    - TBD at this time – dependent on Salud and Timberline Clinics to buy-in to being an alternative site

Estes Park Health Community Paramedic Program

Business Plan

Competition

POTENTIAL COMPETITOR - UCHealth Community Paramedics

SWOT for UCHealth Community Paramedics Operating in the Estes Valley

STRENGTHS (+)	WEAKNESSES (–)
Services provided include: In-home blood pressure checks, risk assessments, fall prevention, medication education and well-check visits to home-bound individuals.	Not local - would require 1.25-2 hours to drive one-way to the Estes Valley to render care.
Experience - In 2017, community paramedics saw over 60 patients/month; administered 300 flu vaccinations; had 1249 patient contacts with 780 hours of patient care. (www.poudre-fire.org/home/showdocument?id=5852)	Not local - care providers are not familiar to the area or to residents.
Timberline Clinic is a UCHealth primary care facility.	Staffing

OPPORTUNITIES (+)	THREATS (–)
UCHealth could definitely offer the same kind of services as the EPH community paramedics for patients of Timberline or post-op patients of downvalley UCHealth facilities.	EPH community paramedics could offer services to UCHealth patients without travel.
UCHealth could compete with EPH ambulance in securing Salud referrals.	For UCHealth to broaden the scope of their service area, their staffing would have to increase.
	EPH ambulance personnel are well known and well respected in the community.
	UCHealth does not currently have IGAs in place with Glen Haven, Pinewood Springs, Big Elk, Allenspark, or RMNP. EPH ambulance does have these in place as well as strong working relationships.

Estes Park Health Community Paramedic Program
Business Plan

Management and Operations

PROGRAM MANAGEMENT AND OVERSIGHT

- The Community Paramedic Program will be managed by a Coordinator with all Community Paramedic Program personnel reporting to the Coordinator. The Community Paramedic Program will report into the EMS Director.
- If any structural or administrative issues arise, the following process for resolution will be utilized:
    1. The Community Paramedic Program Coordinator will identify any decisions needing organizational approval and will present the issue(s) to the EMS Director.
    2. The EMS Director and the Community Paramedic Program Coordinator will discuss and, if needed, engage the Estes Park Health CEO.
    3. If necessary, the Estes Park Health CEO will engage the Park Hospital District Board of Directors. The Park Hospital Board of Directors has the final say in all decisions regarding the hospital, including the ambulance department.
- If any medical issues arise, the following process will be utilized:
    1. The Community Paramedic Program Coordinator will identify any medical concerns and will present the issue(s) to the Medical Director.
    2. The Medical Director and the Community Paramedic Program Coordinator will discuss and, as needed, adjust medical protocols.
    3. The Community Paramedic Program Coordinator will address any State or accreditation agency reportable issues by following the Quality Management Plan and working with the Quality Director at Estes Park Health.

- If any billing issues arise, the following process will be utilized:
    1. The Community Paramedic Program Coordinator will identify any billing concerns and will work with the Estes Park Health billing coordinator to address them.
    2. If necessary, the Community Paramedic Program Coordinator and the billing coordinator will involve the Chief Financial Officer of Estes Park Health.

COMMUNITY PARAMEDIC JOB DESCRIPTION

- General
    - Performs duties in a manner that ensures personal safety, as well as that of the other emergency and medical personnel and the patient(s).
    - Assists with community education, staff continuing education, and/or other EMS related educational functions.
    - Performs non-patient related duties such as assisting with office related functions, performing quality assurance, basic vehicle maintenance (cleaning, stocking, etc.) and assisting at Estes Park Health as requested.
    - Reports for assigned duty shift in timely manner. Participate in shift change communication.
    - Inventory vehicle to ensure that all equipment is operational and adequate supplies are present, and that the vehicle is operational. Report any mechanical problems to the Community Paramedic Program Coordinator or the vehicle maintenance coordinator.
    - Check communication equipment and complete daily checklist and documentation.
    - Receives requests for services from EPH's Triage Line, medical providers, Home Health Services, Hospice Care, and/or ambulance crews. Able to construct a daily schedule for appointments.
    - Able to read maps, run a GPS unit, drive to a patient's home using the most expeditious route and observe all traffic ordinances and regulations.

- Renders appropriate care based on community paramedic protocols and/or direct physician orders.
- Communicates patient condition and treatment to medical control and other medical care providers as appropriate to ensure a continuum of care.
- Executes all required documentation and provides a verbal report as needed.
- Ability to work in an environment of strict confidentiality per HIPAA requirements both at work and in off-hours.
- Examines, screens, treats and coordinates health services for patients.
- Conducts post-hospital release follow-up care, including but not limited to, monitoring medication, dressing changes, and checking vital signs.
- Observes, records, and reports on patient's condition, reactions to drugs, treatments, and significant incidents to physicians or other medical care providers.
- Conducts patient education on the following (but not limited to these): diabetes prevention/treatment, hypertension, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), falls assessment, injury evaluation, mental health evaluations, geriatric frailty visits, nutrition, and other topics as needed
- Administers patient care consistent with department protocols and physician orders.
- Coordinates appointments and follow-up with physicians and hospitals.
- Develops and completes appropriate reports and templates for the Community Paramedic Program.
- Attends meetings as requested and available.
- Other duties as assigned.

- Minimal Job Requirements
  - Must be at least 23 yrs old.

- Associate degree required. Bachelor's Degree preferred.
- Minimum of 5 years EMS experience required with at least 3 years as an EMT-P.
- Training, quality/process improvement, marketing and/or public information experience helpful.
- Professional behavior and ability to be discreet with confidential and sensitive issues.
- Strong verbal communication, written communication, and organizational skills.
- Ability to handle multiple tasks, projects, and meet deadlines.

- Required Certifications
  - Current Paramedic Certification from the State of Colorado
  - Current Community Paramedic Certification from the State of Colorado
  - Current AHA Basic Life Support CPR, Advanced Cardiac Life Support, and Pediatrics Advanced Life Support certifications
  - Valid State of Colorado motor vehicle operating license with safe driving history

STAFFING AND PAY

- Community paramedic staffing will be 24/7.
- Current ambulance department staffing includes two IBSC certified community paramedics with one additional current staff member pursuing certification (expected completion by the end of November 2019). In addition to the full time staff, the Community Paramedic Program proposed staffing model includes two to three additional part-time community paramedics to fulfill additional shift needs. The part-time positions will be posted when the Director of the Urgent Care Center is in place.
- All community paramedics will be employees of EPH's EMS system. For current employees with IBSC certification, no change in relationship status is anticipated. New hires will be hired in accordance with the job description and responsibilities of the Community Paramedic program.
- Through continued education opportunities and competitive compensation for advanced community paramedic practices, EPH is confident in its ability to retain community paramedic providers just as it has a successful retention rate within its Critical Care Paramedic program.
- As needed, additional EMT-level staffing can also be utilized to assist the community paramedics for in-home treatment needs or to accompany the community paramedic for safety.
- The full EMS staff will be engaged in working with the community paramedics to ensure education on and utilization of alternative sites for transport as appropriate.
- Based on the initial estimate of 100 in-home visits per year, the proposed initial staffing is sufficient. As providers refer patients to the Community Paramedic Program, the demand for in-home care and treatment may grow and staff will be augmented accordingly.
- Pay will be in accordance with current EPH ambulance scheduling:
    - Hourly wage from 0700-2300 each day

- On-call pay from 2300 – 0700 with a minimum of 5 continuous hours of sleep required. If the 5 continuous hours of sleep requirement is not met, the community paramedic on call will be paid for the full 8 hours of time.

SUPPLIES AND EQUIPMENT – INITIAL CAPITAL OUTLAY

*Note: Consumable supplies will be absorbed in the ambulance department's budget.

CATEGORY	ITEM	COST
EQUIPMENT	Otoscope *(with camera to send to physician)*	$150
	Stethoscope *(digital to send read-out to physician)*	$450
	BP cuff with memory storage	$100
	Computer	$1500
	Portable Printer (care instructions, receipts)	$300
	Cell phone with "TigerConnect" (sat phone?)	$1000
	Radio (EMS extra will be used)	In hand
	Temporal thermometer	In hand
	Pulse oximeter	In hand
	INR Tester	In hand
	Digital camera	Use phone
	Portable adult scale	$100
	Portable baby scale	$100
	EKG/defibrillators	In hand
	ISTAT	$22,000
	Bandaging supplies, etc.	In hand
	Locking cabinets	$200
	Square credit card processing equipment	Free with acct
LAB	Dressing changes	In hand

SUPPLIES		
	Blood draw equipment	In hand
TRAVEL	Non-emergency vehicle *(lettering, lights, radio if new) – will also be used by ambulance crews as needed*	In hand - Tahoe
Licensing	CIHCS	$3,000
	TOTAL 1st YR CAPITAL	**$28,750**

SUPPLIES AND EQUIPMENT – ANNUAL EXPENSES

*Note: Consumable supplies will be absorbed in the ambulance department's budget.

CATEGORY	ITEM	COST
EQUIPMENT	Square processing charges (2.6% + $0.10/transaction, 100 calls @ $200/call	$526
	Printer ink, paper	$100
TRAVEL	Motor vehicle insurance/gas (estimate 1 tank/wk or 4 tanks/month @ $35/tank)	$1,680
	Tires, maintenance @ $0.50/mile; estimate of 1200 miles/month	$7,200
INSURANCE	Additional malpractice insurance *(Check with insurance company) Should be included in Medical Director Liability*	
UNIFORMS	Community paramedic uniforms ($350 per employee) * 5 employees	$1,750
TRAINING	Tuition, textbooks and supplies ($250/employee/yr)	$1,250
	TOTAL/YR (exclusive of malpractice insurance)	**$11,980**

Financials

FINANCIAL ASSUMPTIONS

- The EPH Community Paramedic Program has applied for the Medicare pilot program "ET3". If accepted, the CPP we will have the ability to bill Medicare for treatment-in-place services and non-emergent transport to alternative destinations.
- Anthem Blue Cross/Blue Shield is a leader in funding community paramedicine programs. It is expected that by successfully negotiating with Anthem for payment for in-home appointments and transport to alternative destinations, other insurance companies will follow suit.
- EPH will have increased revenue through referrals to previously unidentified patients, reconnection with patients that have not been active in their ongoing health, financially insecure patients, and underinsured patients.
- By staffing the Urgent Care Center with community paramedics, the initial out of pocket expenses of starting the new program will be mitigated. This structure will allow for easy ramping up of staffing as needed and utilization of the community paramedics when not on calls.

CAPITAL BUDGET IMPACT

- Approximately $30,000 for first year

ANNUAL OPERATING BUDGET IMPACT

- Approximately $12,000 exclusive of malpractice insurance and salary

Letters of Intent to Operate

1. Salud Clinic
2. Timberline Clinic
3. Estes Park Police Department Dispatch
4. Boards of Commissioners – Larimer & Boulder County

ESTES PARK HEALTH

555 Prospect Ave.
Estes Park, CO 80517
p: 970-586-2317
eph.org

Salud Family Health Estes Park
Marianne Dungan
1950 Red Tail Hawk Dr.
Estes Park, CO 80517

ESTES PARK HEALTH EMS

Greetings Marianne!

I am writing this letter to formally advise Salud Clinic of Estes Park of Estes Park Health's intention to implement a Community Paramedic service to the Estes Valley. This service would operate within the same boundaries that our current 911 systems responds.

Community Paramedicine is a relatively new and advanced EMS provider program within Colorado. Our program will provide "treatment in place" with the abilities to visit patients within their homes in coordination with physician consult.

We are hoping that you will support us in this new endeavor as we strive to improve and move forward in the ever-expanding world of healthcare. If you have any questions or concerns, please contact me at 970-577-4440 or GBeesley@eph.org as we hope to be able to form a working relationship with you as we work to develop this service.

Sincerely

Guy Beesley
EPH Director of EMS

ESTES PARK HEALTH

555 Prospect Ave.
Estes Park, CO 80517
p: 970-586-2317
eph.org

UCHealth Primary Care at Estes Park
Cindy Morgan RN, BSN
Manager of Clinic Operations
131 Stanley Ave, Suite 202
Estes Park, CO80517

ESTES PARK HEALTH EMS

Greetings Cindy!

I am writing this letter to formally advise UCHealth Primary Care of Estes Park Health's intention to implement a Community Paramedic service to the Estes Valley. This service would operate within the same boundaries that our current 911 systems responds.

Community Paramedicine is a relatively new and advancing EMS provider program within Colorado. Our program will provide "treatment in place" with the abilities to visit patients within their homes in coordination with physician consult.

We are hoping that you will support us in this new endeavor as we strive to improve and move forward in the ever-expanding world of healthcare. If you have any questions or concerns, please contact me at 970-577-4440 or GBeesley@eph.org as we hope to be able to form a working relationship with you as we work to develop this service.

Sincerely

Guy Beesley
EPH Director of EMS

ESTES PARK
HEALTH

555 Prospect Ave.
Estes Park, CO 80517
p: 970-586-2317
eph.org

Estes Park Police Dispatch
Sue Pemey
PO Box 1287
Estes Park, CO 80517

ESTES PARK
HEALTH
EMS

Greetings Sue!

I am writing this letter to formally advise the Town of Estes Park Dispatch of Estes Park Health's intention to implement a Community Paramedic service for the Estes Valley. This service would operate within the same boundaries that our current 911 systems responds.

Community Paramedicine is a relatively new and advancing EMS provider program within Colorado. Our program will provide "treatment in place" with the abilities to visit patients within their homes in coordination with physician consult.

We are hoping that you will support us in this new endeavor as we strive to improve and move forward in the ever-expanding world of healthcare. If you have any questions or concerns, please contact me at 970-577-4440 or GBeesley@eph.org as we hope to be able to form a working relationship with you as we work to develop this service.

Sincerely

Guy Beesley
EPH Director of EMS

ESTES PARK HEALTH

555 Prospect Ave.
Estes Park, CO 80517
o 970-586-2317
eph.org

September 27, 2019

Larimer County Board of County Commissioners
200 West Oak St, Suite 2200
Fort Collins, CO 80521

Boulder County Board of County Commissioners
1325 Pearl St
Boulder, CO 80302

Dear Board of County Commissioners,

Pursuant to the requirements of 6 CCR 1011-3, Estes Park Health would like to notify you that it intends to obtain a Community Integrated Health Care Service license. This license will be used to operate a Community Paramedicine program in the Park Health District, which encompasses parts of Larimer and Boulder counties.

Our Community Paramedicine Program is designed to function as an emergency medical service provider as defined in Section 25-3.5-103(8), C.R.S. that has obtained an endorsement in community paramedicine pursuant to Sections 25-3.5-203.5 and 206, C.R.S. and performs, in addition to a paramedic's scope of practice, authorized tasks and procedures and acts within the scope of practice as established in these rules, and 6 CCR 1015-3, Chapter Two including:

- 2.12.1 An initial assessment of the patient and any subsequent assessments, as needed;
- 2.12.2 Medical interventions;
- 2.12.3 Care coordination;
- 2.12.4 Resource navigation;
- 2.12.5 Patient education;
- 2.12.6 Inventory, compliance, and administration of medications; and
- 2.12.7 Gathering of laboratory and diagnostic data.

If you have any questions or would like to learn more about the program, please feel free to contact us.

Respectfully,

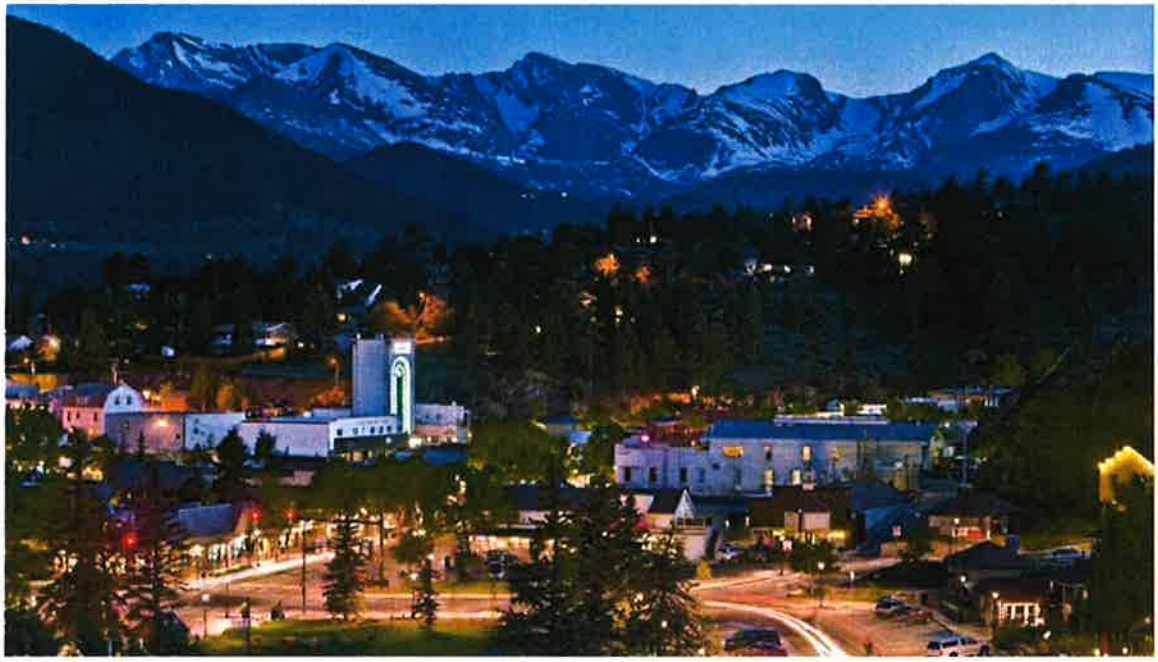
Sharon Lowry-Bielmaier
Estes Park Health
Community Paramedicine Program Administrator
307-321-1626
Slowry-bielmaier@eph.org

Guy Beesley
Estes Park Health
EMS Paramedics Director
970-214-7049
gbeesley@eph.org

Cc: CIHCS application

ESTES PARK COMMUNITY

NEEDS ASSESSMENT



Integrating Community Paramedicine into Estes Park

Written by: Sharon A Lowry-Bielmaier
810 Larkspur Rd, Estes Park, CO 80517
SLowry-Bielmaier@eph.org
Hennepin Technical College
2018

Updated: October 2019

Abstract

The Estes Valley is located 70 miles from Denver Colorado, a major metropolitan hub, and a national healthcare center. The area is accessible via three two-lane state highways. The population in the area is largely aging, with limited access to healthcare due to both geographic and healthcare coverage limitations. Community paramedics can take a major role in area healthcare by providing needed screening and preventative services, filling gaps in coverage, and accessing isolated patients.

Community Paramedicine - Background

Community paramedicine is an emerging and much needed part of the healthcare system in the United States filling an important gap in healthcare coverage and services in most communities. Recent legislation with subsequent state rule changes, both executed and proposed, and the recognition of the specialty from insurance carriers will enable the provision of critical funding to help Community Paramedic Programs develop and grow locally.

Estes Park, Colorado is a unique community in need of community paramedic services. See Map 1. The community is located on the Front Range of Colorado spanning the southern part of Larimer County and northern part of Boulder County. See Map 2. County services vary between the two counties, making the use of county resources and benefits on a local level confusing.

The service area of the Estes Park Paramedics (and the expected service area for the Estes Park Health Community Paramedics) spans the fire protection districts of the Estes Valley and the adjoining small communities of Glen Haven, Pinewood Springs, Big Elk and Allenspark. Residents of these communities consider Estes Park their home. See Map 3.

Estes Park is also the eastern gateway to Rocky Mountain National Park. The Park hosts over four and a half million visitors a year.

From a pre-hospital and emergency preparedness perspective, Estes Park is on the west edge of the "Northeastern Regional Emergency and Trauma Advisory Council (NERETAC). This region is made up of EMS providers of all sizes and configurations including metropolitan high-performance systems and small volunteer providers. Estes Park has a Level IV Critical Access hospital administered by the Park Hospital District Board of Directors. Estes Park Health is an independent facility that is isolated from large healthcare systems, making collaboration with like agencies difficult.

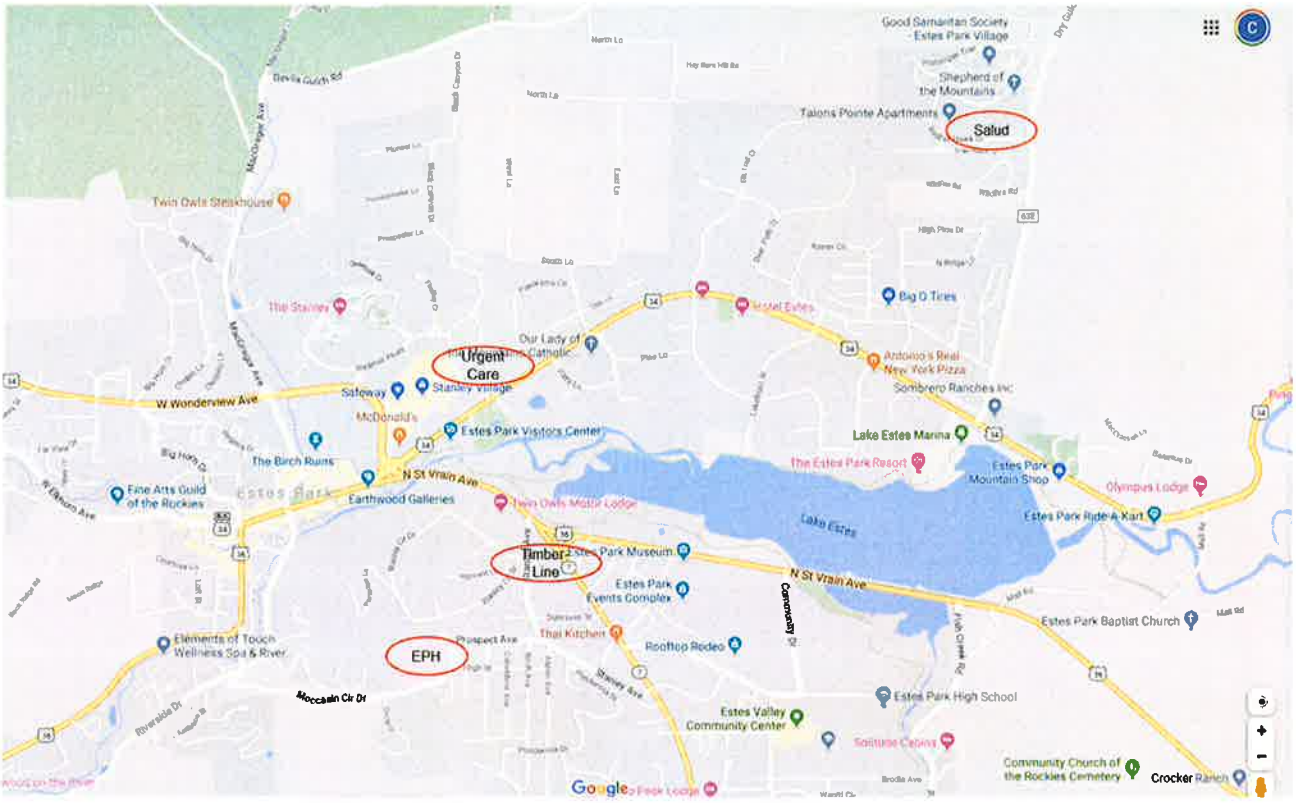
The geography of the area creates a challenge for residents, visitors, patients and responders. The topography is mountainous with elevations ranging from 7,500 ft in the town proper to over 14,000 in Rocky Mountain National Park. Many health conditions are exacerbated by a relative lack of atmospheric oxygen due to elevation.

While generally temperate, the climate has extremes of heat and cold. Many residents live on rural roads with limited accessibility due to the narrow size of the road and frequent lack of maintenance, weather damage and lack of snow removal in the winter. Leaving home can be inconvenient making it "not worth it" to leave and go to see a doctor or to get prescriptions filled/re-filled.

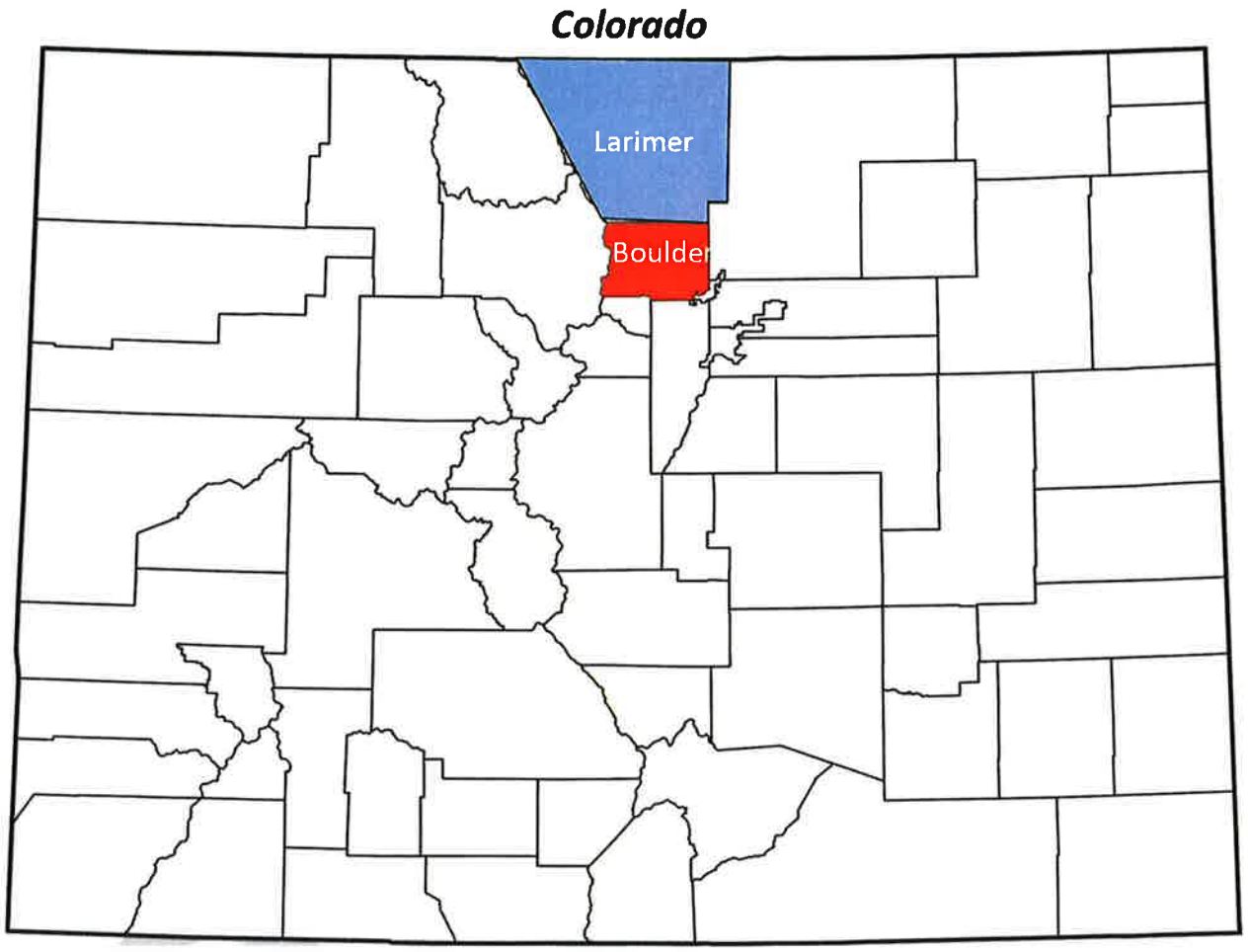
Estes Park is a small community with population that includes residents that are elderly, disabled, financially insecure, or under/uninsured in need of wellness and diagnostic care. The area has a narrow demographic of largely educated, retired white adults with conservative political views. The median age of 56.6. Industry is limited. The major employers include the Town of Estes Park, the YMCA of the Rockies, and Estes Park Health. Unlike the residents of the incorporated Town, residents in the outlying areas tend to be under and uninsured. Often, Medicaid and Medicare patients remain at home, not reaching out to take advantage of basic services and resources.

The Town of Estes Park and surrounding area will benefit from a robust Community Paramedic Program that would improve available services including shot clinics, home visits, coordination with Estes Park Health, Salud Clinic, Timberline Clinic, home health services and hospice care, and integrating and coordinating community resources including the county health nurse.

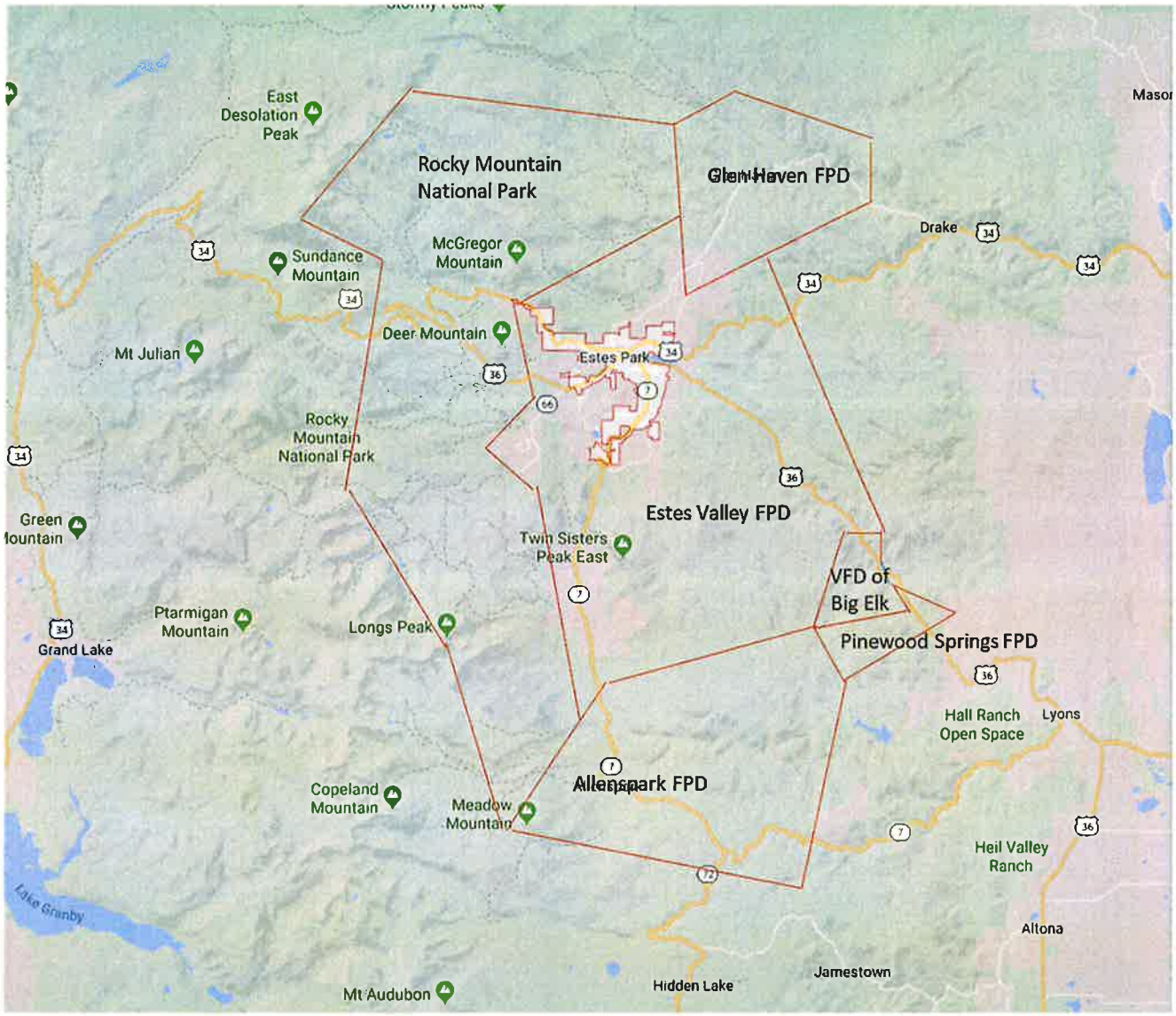
Map 1: Estes Park



Map 2: Larimer and Boulder Counties



Map 3: EPH Paramedics & Community Paramedics Service Area



Location and Demographics

The median age of Larimer County is increasing, with 2013 U.S. Census reports indicating that 13.3 percent of residents are aged 65 and over (up from 11.9 percent in 2010). Projections for the year 2020 predict that the local population segment aged 65 and older will grow at a rate faster than the state's overall growth rate for that demographic (Larimer 26 percent, Weld 30.7 percent, Colorado 25.9 percent). (Health, 2016)

The current population of Estes Park is 6,362 (2018) with the median age being 56.6 years old; this is 20.1 years older than the average Larimer County resident. The community is over 93% Caucasian.

"Ten percent of the people living in Estes Park are living in poverty, while 3% of people over 65 function below the poverty line. This is lower than Larimer County by 2.3%, Colorado by 4.4%, and 6.4% less than the national averages. Over 56% of Estes Park residents living in poverty are single mothers." (Strategies, 2017)

The economy is mostly supported by healthcare institutions, with Estes Park Health being one of the most significant employers in the area. The Town of Estes Park and YMCA are the other big contributors to the employment in the area. Many novelty businesses are open only in summer months providing seasonal employment. Anchor businesses including grocery stores restaurants, motel/lodges, coffee shops, and gift shops are open year-round providing additional employment. The employees typically spend money locally, which produces secondary jobs and creates an additional economic impact in the area.

Area History

Larimer County is in the north-central portion of Colorado and is a combination of expansive rural, agricultural land and concentrated urban areas. The town of Estes Park was established in 1820. Nestled in a beautiful mountain valley surrounded by Rocky Mountain National Park and Roosevelt National Forest, Estes Park is located about 30 miles west of Loveland Colorado and 75 miles northwest from Denver International Airport. Estes Park is an isolated community that is over an hour of mountain driving time from the next major city.

Ute and Arapaho native Americans were the first residents of the Estes Valley. The town is named after a Missouri native, Joel Estes,[9] who founded the community in 1859 and moved his family to the area in 1863. Estes Park sits in a valley and has limited access in winter months. The climate can be harsh during the winter with the snow that settles and can cause limited access because of closures of roads to Estes. The roads into Estes are two lane mountain highways.

During the spring, summer, and fall, Estes Park draws thousands of outdoor enthusiasts to outdoor activities including hiking, biking, camping, swimming, rock climbing, four wheeling and numerous other activities. Residents and numerous visitors come to enjoy the amenities.

The small mountain communities of Glen Haven, Pinewood Springs, Big Elk, and Allenspark adjoin the Estes Valley. These small mountain communities have a strong foundation base of permanent residents that live there year-round whereas the town of Estes Park has a large population of seasonal residents.

The climates of Glen Haven, Pinewood Springs, Big Elk and Allenspark are similar to that of Estes Park although these smaller communities have even more limited access via two-lane maintained and unmaintained county roads with limited maintenance, including limited snow removal.

Glen Haven was established by the Knapp family in 1890 when they built a sawmill in the area. The sawmill was moved to town of Glen Haven in 1897. In 1903, the family formed an association with The Boulder Presbytery and started to sell lots to people. Mrs. Knapp started the General Store in 1921 and by 1938 the family had built the hotel called "The Homestead". The flood of 1976 moved the Town Hall several feet off its foundation. In 2013, approximately 80% of Glen Haven was destroyed by another flood and all access was cut off for a time because it had destroyed the roads going into the community.

Glen Haven has a population of 151 with the highest age group being 25-36, followed by the age group 45-54. It is considered an unincorporated community in the Larimer County.

Allenspark, first called Allen's Park, was established in 1864 when a miner built a cabin there. Alonzo Nelson Allen prospected and ran cattle up and down the valley. Then George Mack decided to homestead there and built a cabin where Allenspark is currently located. Mack was granted a homestead patent 01-07-1895 and sold some land to Allen's Park Land and Townsite Co on 05-09-1896. He never filed his homestead deed, so he technically had been squatting on it since arriving in 1864. The only thing he did do was give Allenspark its name.

In the 1890's, most of the Allenspark residents were farmers and ranchers until the 1900-1920's when the gold fever hit. Many people came up the South St. Vrain canyon from Longmont, and a number came from as far away as Kansas and Oklahoma in that initial burst. The greater Allenspark area extends beyond the village to include the small communities of Ferncliff, Longs Peak, Meeker Park, Peaceful Valley, Raymond, and Riverside; it is defined by the boundaries of the Allenspark Fire Protection District. Allenspark's population is 528 with a median age 60.3. The elevation of Allenspark is 8450 feet.

These mountain communities used to be primarily summer destinations until improved roads and modern technology made mountain living easier than it used to be. Now, many people live year-round. These communities do not have a sustainable economic base, depending on Estes Park for support and services.

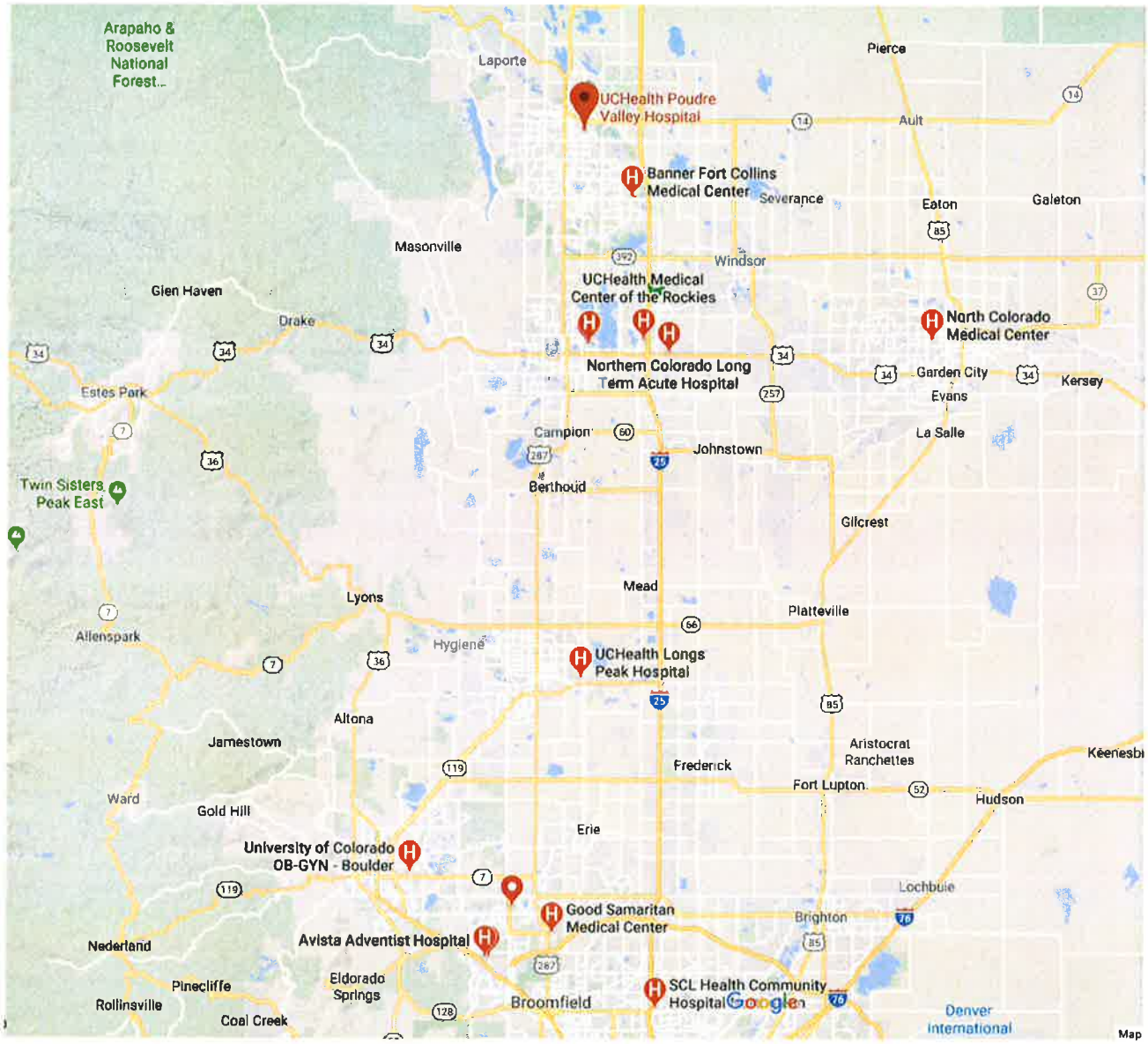
Healthcare Systems and Services

Being nestled in the mountains can be challenging for those in the area to gain access to high quality, affordable healthcare. Estes Park tries to meet those needs between the hospital and health clinics in town.

Larimer County, outside of Estes Park, has four hospitals, one free standing emergency room, three urgent care centers, numerous specialists, and, a variety of primary care providers. Three clinics serve the uninsured and homeless populations. These serve the residents of the 2640 square miles of Larimer County. Northern Boulder County has three hospitals, Boulder Community, Longs Peak Hospital, and, Longmont United Hospital. There are other resources available in Boulder County that do not directly affect the needs of southern Larimer County and the Estes Valley.

The hospitals used by the residents of Larimer County are Estes Park Health, Poudre Valley Hospital, Medical Center of the Rockies, McKee Medical Center, and, Banner Fort Collins. Southern Larimer County residents also utilize Longmont United and Boulder Community Hospital in Northern Boulder County. See Map 4.

Map 4: Closest Hospitals to Estes Park



Hospital Systems

Estes Park Health (EPH)

Located in Estes Park, Estes Park Health (EPH) is a 23-bed, Level IV Critical Access Hospital. It has a 24-hour emergency department, a 24-hour Advanced Life Support Ambulance Service, medical/surgical services, obstetrics, home health services, hospice services, and a 60-bed skilled nursing facility that offers immediate and skilled healthcare needs.

The EPH Physician Group offers family medicine, obstetrics and gynecology, general surgery, internal medicine, orthopedics, ophthalmology, podiatry, and pediatrics as part of the patient centered continuum in the community.

The EPH Specialty Clinic provides a range of specialists from the Front Range who provide services on a limited appointment basis, including allergy/asthma, cardiology, dermatology, oncology, infusion therapy, orthopedics (neck & spine), otolaryngology, neurology, pulmonology, rheumatology, and urology.

University of Colorado Health (UCH)

UCH is a regional health system that owns and operates three facilities in Larimer and Boulder County: Poudre Valley Hospital in Fort Collins, Medical Center of the Rockies in Loveland, and, Longs Peak Hospital in Longmont. These facilities operate independently within the regional system. Mountain Crest Hospital, also part of the UCHealth system, is a dedicated mental health hospital serving the community and region. The services offered through the system include bariatric, behavioral, cancer center, cardiovascular, vascular care, neurology, women's care, orthopedics, primary and urgent care, emergency care, endocrinology, pediatric specialty center, pulmonary, rehabilitation, urology, hyperbaric and wound care, rheumatology, general surgery, radiology, gastroenterology, nephrology, and stroke centers. (Health, 2016)

Poudre Valley Hospital (PVH)

Located in Fort Collins CO, PVH is a Level III Trauma Center. The Hospital is a 231-bed hospital that specializes in orthopedic surgery, neuroscience, cancer, bariatric weight loss surgery, and women and family services for residents of northern Colorado, southern Wyoming and western Nebraska.

Medical Center of the Rockies (MCR)

Located in Loveland CO, Medical Center of the Rockies is a 166 bed Level II trauma center and regional medical center in Loveland, CO, offering a full spectrum of services. It specialized in heart and trauma care.

Longs Peak Hospital (LPH)

Located in Longmont CO, LPH is a Level III Trauma Center. It has 51 inpatient beds with room to expand to more than 100. It features an intensive care unit, operating rooms, advanced cardiac services and a surgery center. It also has a 24-hour retail pharmacy, laboratory and imaging services, birthing center, bariatric surgery, advanced orthopedic procedures, advanced telehealth services, and a Sexual Assault Nurse Examiner (SANE) program. (UCHealth, 2018)

McKee Medical Center (MMC)

Located in Loveland, Colorado McKee is a 115-bed, acute-care hospital that has served the Loveland CO community for more than 30 years. It is also the area's hospice center.

Banner Fort Collins Medical Center (Banner)

Located in Fort Collins CO, Banner is a full-service, acute-care hospital that has the capacity to expand to 144. It offers emergency care, orthopedics, general surgery, women's health, labor and delivery, gastroenterology, urology, pulmonology, intensive care, cancer and surgical services and offers emergency, medical, surgical, obstetrics, internal medicine, cardiology, orthopedics, pediatrics, oncology, neurology, pulmonology, and urology. (Banner Health, 2018)

Longmont United Hospital (LUH)

Located in Longmont CO, LUH is a Level III Trauma Center full-service, 201-bed, non-profit hospital. Specialty areas include Women's Services, Orthopedics, Cardiology, Oncology, Robotic Surgery, Transitional Care and Acute Medical Services. (Longmont United Hospital, 2018)

Boulder Community Hospital (BCH)

Located in of Boulder CO, BCH is Level II Trauma Center and is a community owned-and-operated not-for-profit health system. BCH provides cardiology, neurosurgery, stroke care, orthopedics and cancer care, and emergency services. (Boulder Community Health, 2018)

Other Medical Providers in the Estes Valley

Salud Clinic

Salud is a Federally Qualified Health Center that provides medical, dental, pharmacy and behavioral health care services to low-income, medically under-served populations in the Estes Valley. Salud can provide family medicine and pediatric services, preventative care, chronic illness management, and lab, xray and ultrasound services.

Timberline Clinic

Timberline Clinic provides primary care services during normal business hours M-F to many in the community. Services include preventative care, management of chronic diseases, geriatric services, immunizations, and allergy injections as well as routine exams and testing.

Under construction: Estes Park Health Urgent Care Clinic

EPH Urgent Care is currently under construction with an anticipated opening by April 30, 2020. The facility will provide general care services, vaccinations and immunizations, basic diagnostic imaging, and lab work.

Other Medical Services in the Estes Valley

Case Management

Each hospital system offers other general services for the communities. Typically, case managers visit patients with chronic needs due to mental, physical or disease processes in their homes to make sure they have what they need to be successful on their own. The case managers will have weekly visits to see how their patients are doing and to adjust things as needed. There is no time limit on this service, but case managers try to have patients successfully graduate from the program within a set period that is established at the beginning of the care. Medicare and Medicaid patients have special case managers because there are other programs that are available to these individuals and the time that is set to work with these patients can be lengthy.

Diabetic Education

Diabetic educators are available to patients recently diagnosed with diabetes or who are having a hard time managing their disease. These educators are available during the day to work with patients to try and help them understand their disease in depth and to help them understand how important it is to manage their disease to prevent the possible negative side effects of this disease as it progresses. For the patients who are having a hard time managing their disease, they are there to help them navigate the possible other options that are out there and to talk to their doctor about those choices.

Child Services

"Wee Steps" is available for new moms learning how to nurse and to those that aren't nursing, it is a program on the how's and what's of being a new mom. The program has individual appointments to check infants' health and to talk with the moms about concerns or questions they may have. Wee Steps will hold group meetings every day, so the moms and babies can come together, and they can share experiences and just have support and talk.

Critical Incident Stress Management

A Critical Incident Stress Debriefing (CISD) Team is a hospital wide team that is available 24/7 to call and step up debriefing and defusing after a major event. There are people on the team from all departments of the hospital that have been trained under the same Mitchell Model so anyone can show up and know what is expected. There is also an EMS specific Peer Support Team that has been developed for the UCHealth EMS department that supports them and their specific needs and they support other EMS agencies as well.

Healthcare Needs and Disparities

Although the term "*disparities*" is often interpreted to mean racial or ethnic disparities, there are many dimensions of disparity in the United States, particularly in health and healthcare. If there is a difference in health outcomes between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health through access to good healthcare. It is important to recognize the impact that social determinants have on health outcomes of specific populations as well. For example, rural areas with limited access to good healthcare often result in different health outcomes especially for the elderly and young.

Healthy People 2020 defines a *health disparity* as, "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender exclusion." (Healthypeople2020, 2017)

- "To better understand the context of disparities, it is important to understand more about the U.S. population. In 2008, the U.S. population was estimated at 304 million people.[1]
- In 2008, approximately 33%, or more than 100 million people, identified themselves as belonging to a racial or ethnic minority population.[1]
- In 2008, 51%, or 154 million people, were women.[1]
- In 2008, approximately 12%, or 36 million people not living in nursing homes or other residential care facilities, had a disability.[2]
- In 2008, an estimated 70.5 million people lived in rural areas (23% of the population), while roughly 233.5 million people lived in urban areas (77%).[3]

- In 2002, an estimated 4% of the U.S. population ages 18 to 44 identified themselves as lesbian, gay, bisexual, or transgender (Healthypeople2020, 2017)."

Over the years, efforts to eliminate disparities and achieve health equity have focused primarily on diseases or illnesses and on healthcare services. However, the absence of disease does not automatically equate to good health.

Powerful complex relationships exist that influence an individual's health known as "determinants of health." These include relationships between health and biology; genetics, individual behavior, and between health and health services. Additional factors include socioeconomic status, the physical environment, discrimination, racism, literacy levels, and local, county, state, and federal legislative policies.

For all individuals, availability of and access to basic human needs must be present: high-quality education, nutritious food, decent and safe housing, affordable and reliable public transportation, culturally sensitive healthcare providers, health insurance, clean water and non-polluted air. When individuals are forced to focus all their time, money and energy on supplying the above needs they will not spend any time or effort on their healthcare needs. Without these basic health and emotional needs met, personal and community health will not exist. Steps toward health equality will be achieved in part through access to healthcare through robust community paramedic programs. Community paramedics can make vital care available where it is currently not.

Larimer County

> "Within the *Larimer County Community Health Needs Assessment*, major disparities were identified in low income, minority, and, uninsured individuals. The community health assessments and prioritization activities carried out by each UCHealth hospital in Colorado concluded that access to care, cardiovascular disease (and related risk factors) and mental and behavioral health (including a special focus on suicide prevention and substance abuse treatment and prevention) are the community health issues that achieved the highest priority and therefore should be the focus implementation strategy's for the communities they serve (Health, 2016).

Improved transportation is a key social determinant of health in these groups. Improving transportation improves access. Transportation to, from, and, between healthcare facilities or, bringing care to the patient through the community paramedic will positively impact these disparities.

Estes Park and surrounding communities

In comparing the local population to the national standards quoted above, it stands as follows:

"1. The current population of Estes Park is 6,362 (2016), which is a growth almost 10% since 2010.

2. The median age of Estes Park residents is 58.6 (as of 2019), 20.1 years older than the average Larimer County resident.

3. Corresponding to the median age, females make up 52% of Estes Park population, 2% higher than Larimer County, Colorado, and the nation.

4. People over the age of 65 constitute over 25% of all people living in Estes Park. This is 53% higher than Larimer County, 57% higher than Colorado, and 49% higher than the country.

5. The Estes Park community is predominantly Caucasian, contributing 92.3% of the population. Following are the race and ethnicity demographics, ranking by density:
    a. Latino/Hispanic, 14%
    b. Other unspecified, 5.9%
    c. Asian, 1.2%
    d. American Indian/Native American, 0.5%
    e. African American, 0.3%

6. Statistics indicate that at least 11% of people over 65 live with people younger than the geriatric demographic, in Estes Park.

7. Nearly 25% of the economy in Estes Park is based on healthcare and social services. In comparison, recreation (including tourism), makes 20% of the Town's revenue base.

8. The gender inequity ratio in Estes Park is higher than its comparisons. Males in Estes Park make an average of $12,192 more a year than their female professional counterparts. Yet, unemployment is significantly lower than its comparisons, sitting at 3.7%.

9. Estes Park's mean household income is 12% less than Larimer County, 16% less than Colorado and 10% less than the national average.

10. 10% of people living in Estes Park are living in poverty, while 3% of people over 65 functions below the poverty line. This is lower than Larimer County by 2.3%, Colorado by 4.4%, and 6.4% less than national averages. Over 56% of Estes Park residents living in poverty are single mothers (Strategies, 2017)."

Data derived from state and national resources indicated a few health observations needs in Estes Park. Among them were:

1. Larimer County's air particulate matter rate is 31% higher than Colorado and 15 % higher than the United States.[1516]

2. 27% of those living in poverty have less than a high school education, or the equivalent, but no higher education.[17]

3. Only 32% of three to four-year-old children are enrolled in preschool, which is 36% less than Larimer County, 37% less than Colorado, and 33% less than the United States.[18]

4. 14% of Larimer County has low income and low access to healthy foods.[19]

5. Estes Park's veteran population is 40% higher than Larimer County and 33% higher than the Colorado density.[20]

6. Estes Park's publicly insured population is 34% higher than Larimer County and 27% higher than Colorado.[21]

7. 12% of live births are to unwed mothers.[22]

8. 10% of residents report frequent physical distress while, 9% report frequent mental distress.[2]

9. Populations with at least one disability are higher in Estes Park are 27% higher than Larimer County, 20% higher than Colorado, and 5% higher than the national average.[24]

10. 19% of residents are obese, and 13% of adults identify as smokers (Strategies, 2017)."

The observations made from the results were the following:

- The most important health concerns were, by ranking:
- Aging problems
- Heart disease and stroke
- Mental health
- Respiratory/lung disease
- Cancer
- Access to healthcare

Disparities exist across the country. Colorado, Larimer County, and, the Estes Valley are no exception. These disparities amplify and complicate filling gaps in care. No community paramedic program will be successful until these entities acknowledge this.

Gap Identity General

Larimer County Health Needs Assessment noted that the gaps needed in Larimer County and Fort Collins and Loveland were based on the information collected from the sources shown above, it is concluded that access to care, cardiovascular disease (and related risk factors) and mental and behavioral health (including a special focus on suicide prevention and substance abuse treatment and prevention) are the community health issues that achieved the highest priority and therefore should be the focus of Poudre Valley Hospital / Medical Center of the Rockies' Community Health Needs Assessment Implementation Strategy. (Health, 2016)

Estes Park Gaps

The Estes Park Community Health Needs Assessment noted the gaps in Estes to be:

- Improve cost and billing
- Improve physician retention
- Improve spiritual support
- Improve preparation for appointments
- Increase dialysis
- Increase urgent care
- Health system integration
- Free, public yoga
- Increase retail pharmacy
- Improve hospital culture
- Improve mental health services
- Increase community decision making
- Improve oncology services
- Implement adult day care
- Increase complementary and alternative medicine
- Improve housing options

- Increase appointment availability
- Reduce outmigration
- Implement assisted living
- Improve health literacy
- Increase primary care clinic hours

Based on these and other more detailed data, the attendees at the community stakeholder meetings recommended the following opportunities:

1. Improve mental health services, while decreasing community substance abuse
2. Increase child, infant and elder care opportunities for all income levels
3. Increase access to health services for minority populations, specifically around race and ethnicity
4. Improve affordable housing opportunities within the community (Strategies, 2017)

Estes Park Community Paramedic Program Proposal - 2018

Stakeholders:

To initiate a strong foundation to develop a Community Paramedic Program in the Estes Park Valley and surrounding areas, the following major stakeholders would be invited to engage in a plan development:

- Estes Park Health
- EPH Physician Clinic Director
- EPH Chief Financial Officer
- EPH EMS Director
- EPH EMS Medical Director
- EPH Home Health and Hospice Director
- EPH Case Management/Discharge Planner
- UCHealth Timberline Clinic
- Town of Estes Park
- Receiving Facilities Discharge
- Larimer County Health Nurse
- County Health and Human Services
- Crossroads Ministry of Estes Park
- Estes Park School District
- Salud Clinic

These stakeholders will assist the EPH EMS Director as the facilitator of the program to:

- Identify the scope of the program in the Estes Valley
- Design referral pathways to gain access to the program care givers

- Identify available funding available currently and funding available in the future

These stakeholders will not ultimately oversee the program. The program be part of EPH's EMS department and will be administered and overseen by the Community Paramedic Program Coordinator, EPH's Medical Director, and the EMS Director.

The Community Paramedic Program scope will include description of appropriate patient base, staffing needs for identified appropriate availability, protocols and equipment needed, best means of community paramedic transportation, identification of the community paramedic's communication needs to be able to communicate in real time to primary care physicians and the Program's Medical Director.

Referral pathways will include:

- Educating medical and ancillary community partners about the appropriate community paramedic patient
- Accessing the community paramedic staff for appointments, emergency or unscheduled responses
- Identification of appropriate medical staff for the community paramedic to work with in the patient's interests.
- Identify currently available funding through existing programs.
- Identify Medicare/Medicaid funding available and quantify value of revenue retained by reducing readmission rates, avoiding unneeded access to the Emergency Dept by making home visits and referrals.
- Monitoring and utilizing private pay sources as they become available.
- Implementation of the program will rest with the Community Paramedic Program Coordinator, the Program's Medical Director, and the EMS Director and/or their representatives.
- The Community Paramedic Program Coordinator will be responsible for creating policy and procedures for the program, identifying staff uniform, scheduling procedures, and medical protocols for the program based on identified scope.

(Sample protocols Attachment A), creating a working budget including initial cost of the program, and tracking ongoing monthly expenses to include the development of a cost to benefit ratio.

Example of Program Statement

"Estes Valley Community Paramedics will contribute to a healthy community by providing care to members of the community in the form of wellness and preventative care, referral to appropriate care through appropriate channels. Serve members of the community that do not have access to traditional means early, decreasing burden on the system by diagnosing and treating early with a variety of available resources."

Examples of Referral Patterns

- County Health Nurse requests follow-up on patient after visit to county health clinic for treatment of respiratory difficulty.
- Home Health requests assistance with follow-up on patients that need extra assistance but do not meet insurance requirements for extra assistance with medication or ongoing assessment and emotional support and training for family members.
- Assist the Primary Care Clinic by utilizing the CP to go and visit patients that were unable to obtain a "same day appointment" for patients that the physician felt needed and assessment/evaluation. CP will do an evaluation and consult the primary care physician for orders, appointment recommendations etc.
- Creating a "clinic" environment in areas outside of Estes Park, Glen Haven, Pinewood Springs, Big Elk, and Allenspark to make basic assessments available with opportunity to ask questions and learn about healthcare options will create a "win-win" by helping community members become healthier and by creating referral options for the local health system.
- Patients discharged from facilities that did not meet the criteria for home health could be referred to the Community Paramedic Program for follow up within 24-48 hours and then followed to prevent readmission. Patients admitted to the

program would be in the program for 30-60 days with an expected successful graduation from the program at that time. Exceptions will be made as necessary for patients with long-term illnesses/diseases needing more extensive care and/or time.

Use of these programs will prevent unnecessary or inappropriate utilization of the 911 system and or admission to the hospital system.

Community Paramedics will also be available for referral from EMS when patients needing non-urgent or emergency care call CP will provide an appropriate referral avenue.

Sample Budget

Specific budgeting will fall to the coordinator of the program as part of department and program funding. Many of the equipment needs of the community paramedic are common to EMS and do not represent a large budgetary commitment. The largest items in the Community Paramedic Program budget are represented by staffing and vehicle cost. A sample first year budget is represented in Attachment B.

Level of Care

Patients in the care of the community paramedics receive physician-assisted care. With a basis in emergency medical training at the paramedic level, community paramedics have an in-depth foundation in patient care. Formal community paramedic training expands training in patient assessment, data collection and analysis, lab values, and medication use, interaction, and administration. The proposed protocols to be used are based on the "PEAT Scale," Physical Environment Assessment Tool." Developed to assist EMTs and paramedics to have a standardized means of reporting home situations that are unacceptable, giving the community paramedic the needed tools for an accurate and quantifiable tool. (Attachment C) (Erickson, 2004)

Conclusion

Community Paramedicine programs are evolving around the country. The role of the community paramedic will be both integrated and expanded as an important piece of the patient's healthcare team. The community paramedic must form working relationships within the existing healthcare structure, including primary care physicians, EMS personnel, nurses, social workers, case managers, hospice, and other care providers to fill the existing gaps in the healthcare continuum.

In small health systems building the most efficient and cost-effective team is important for the success of care in the community. Providing the best available patient centered care, will benefit the healthcare system in many ways. To measure the success of the Community Paramedic Program, many aspects will need to be considered. Financial measure in revenue generated, downstream revenue through referral and cost saving through decreasing readmission is a concreate measure. Gains in overall patient health and satisfaction are equally important. The Community of Estes Park identified community wellness as an important part of their community several years ago. As a community and healthcare system, Estes Park will need to embrace this practical and cost-effective option. Community Paramedicine is going to be a vital link in the best practices available.

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ESTES PARK HEALTH

1st Quarter Financials
2020

Prepared For:

Board of Directors

Prepared By:

Tim Cashman, CFO

2020 1st Quarter
Overview

The impact of the COVID-19 event has shown a profound impact on the Hospital.

- Before March 19, visits were tracking close to budget; Net Revenues were very close to Budget.
- After March 19, after the Governor's Executive Order to "Cease All Elective Surgeries and Procedures and Preserve Personal Protective Equipment and Ventilators due to the presence of COVID-19";
  - Most patient visits ceased. Including Clinic visits, Ancillary and, Surgical;
  - Emergency Department experienced a decline;
  - Overall Revenues declined by 60%. (This is still the case)
- Incident Command was established resulting the development of the "Operations Committee".
- Staffing remained generally intact, intending to evaluate the situation and sustain the employees thru April.

2020 1st Quarter Overview

Revenues for the 1st Quarter are $2.3M under Budget and $1.8M under last year.

- Inpatient days are dramatically less than Budget.
- Swing beds days continue to report lower numbers
- Outpatient revenues are close Budget.
- Loss of the Sterilizer in early October has had dramatic impact on Surgeries and recovery is very slow.

Expenses are slightly over Budget and 17% higher than last year.

- Principal impact is Physician Contract Labor and Supplies

Total Earnings are $1.5M less than Budget due to the decline in business volumes/revenues

ESTES PARK HEALTH

2020 1st Quarter
Overview

Balance Sheet ratios are suddenly very interesting:

- Days in Accounts receivable have dropped to 53;
- Days Cash on Hand are 132, less than last year. Use of Cash will continue to decline due to the COVID-19 pandemic.

Cash Flow is now negative and projected to become much worse over the year, with a loss of potentially $7M.

ESTES PARK HEALTH

2020 1st Quarter
Overview

Support

As a result of the recent support from the Federal Government, via several programs have provided funding in April:

Advance Payment Program $4.4M
-currently scheduled for repayment; possibility of forgiveness

HHS Stimulus $702K
-forgivable

Payroll Protection Program $4.8M (approved; pending)
-eligible for forgiveness assuming compliance with stipulations.

ESTES PARK HEALTH

Key Areas of Variance

REVENUES

- Inpatient, Swing and Observation are down by $925K
- Birth Center is down by $126K
- Surgery and Anesthesia down by $713K and $117K, respectfully
- Emergency Dept down by $91K
- Ambulance/EMS is down $48K
- Lab, Radiology, Pharm & Rehab down by $730K
- Clinic Physicians down by $100K
- Cardiology Clinic down by $121K

EXPENSES

- Contract Labor over Budget by $281K
- Supplies are over budget $338K

ESTES PARK HEALTH

Key Drivers of Financial Performance

	2020	Budget	2019
Inpatient Days	**163**	**235**	**273**
Swing Bed	87	122	83
Births	12	21	18
ER Visits	1,066	1,025	1,025
Ambulance Trips	418	410	410
Clinic Visits	5,160	5,194	7,513
Surgeries (not incl GI)	156	210	176
GI Procedures	120	104	71
Lab Tests	16,338	17,589	17,589
Radiology Exams	2,352	2,512	2,512
Rehab Visits	2,083	2,611	2,780
Home Health/Hospice	2,306	2,314	2,371
Living Center Days	2,985	3,420	3,285

ESTES PARK HEALTH

Summary of Profit and Loss

	Actual 2020 YTD	Budget 2020 YTD	Variance $	Prior Year 2019	Prior Year % Var
Patient Revenue	19,309	21,602	(2,294)	21,091	-8%
Total Revenue Deductions	(8,564)	(9,937)	1,374	(10,409)	-18%
Total Operating Revenue	10,864	11,874	(1,010)	10,855	0%
Total Operating Expenses	14,805	14,413	392	12,703	-17%
Operating Income (Loss)	(3,941)	(2,539)	(1,402)	(1,847)	-113%
Non-Operating Income	793	849	(56)	774	3%
Gift to Purchase Capital Assets	-	100	(100)	15	0%
Increase (Decrease) in Net Assets	(3,147)	(1,589)	(1,558)	(1,058)	197%
EBIDTA	(2,366)	(725)	-	(461)	0%

ESTES PARK HEALTH

Cash Flows

Statement of Cash Flows (Unaudited)
1/1/20 through 3/31/20

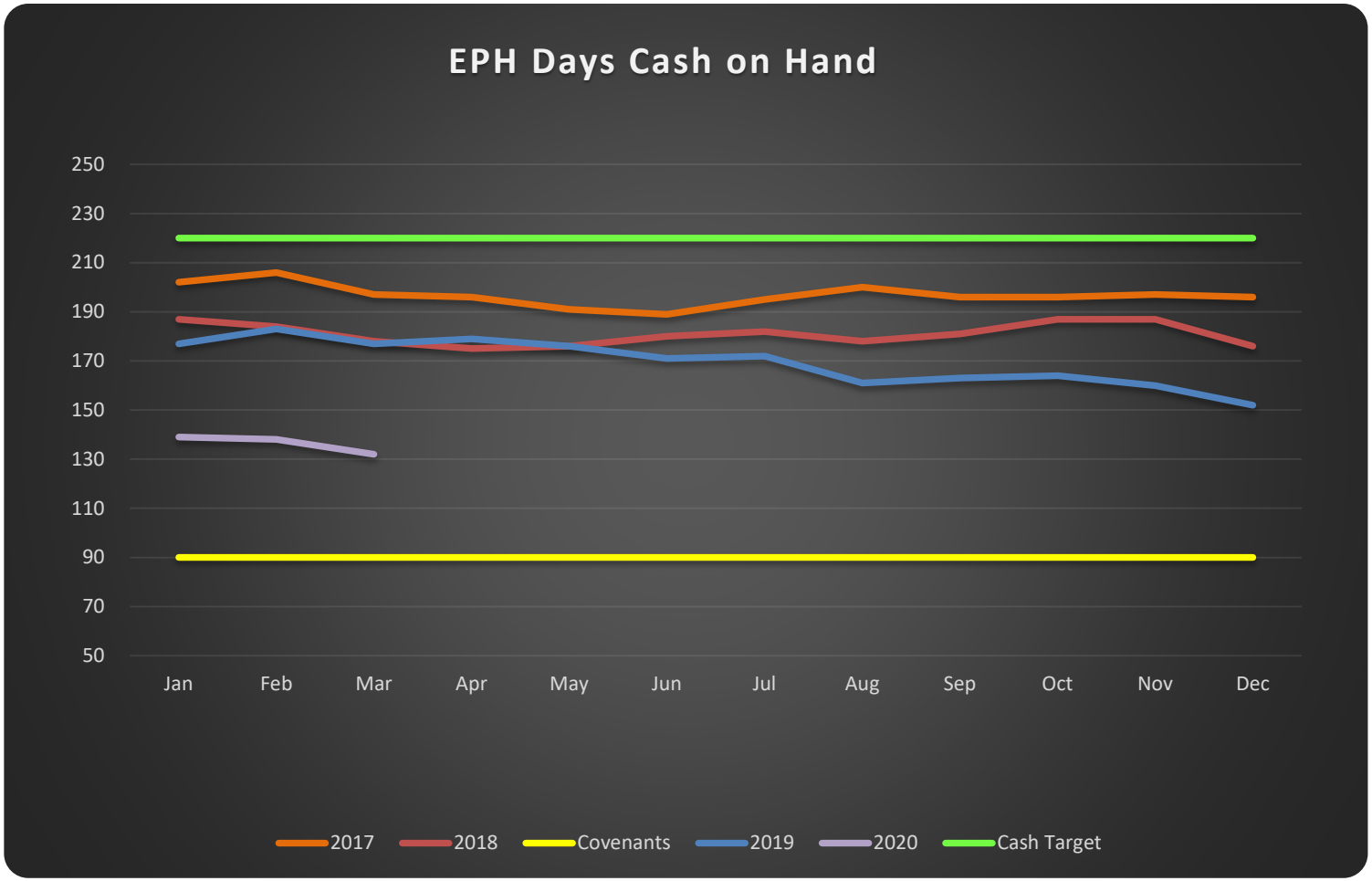
Cash Flows From Operating Activities	
Net cash provided by (used in) operating activities	(1,627,688)
Cash Flows From Financing Activities	
Net cash provided by (used in) financing activities	(823,990)
Cash Flows From Investing Activities	
Net cash provided by (used in) investing activities	(44,034)
Net Increase (Decrease) in Cash and Cash Equivalents	(2,495,711)
Cash and Cash Equivalents, 01/01/2020	20,744,349
Cash and Cash Equivalents, 3/31/20	$ 18,248,638
Restricted Cash and Cash Equivalents, 3/31/20	$ 1,413,976
Unrestricted Cash and Cash Equivalents, 3/31/20	16,834,662
	$ 18,248,638

Forecast 2020

ESTES PARK HEALTH Statement of Revenues and Expenses (Unaudited) Forecast 2020						
	YEAR TO DATE 1st Qtr 2020	FORECAST FY 2020				
REVENUE	Actual	2nd Quarter	3rd Quarter	4th Quarter	FY 2020 Forecast	Budget 2020
TOTAL OPERATING REVENUE	10,864,062	6,977,716	11,933,959	10,084,092	39,927,532	53,750,778
TOTAL OPERATING EXPENSE	14,804,615	11,836,466	14,248,707	14,248,707	55,138,494	57,159,152
OPERATING INCOME (LOSS)	**(3,940,553)**	**(4,858,750)**	**(2,314,748)**	**(4,164,615)**	**(15,210,962)**	**(3,408,374)**
Operating Margin	*-36.3%*	*-69.6%*	*-19.4%*	*-41.3%*	*-38.1%*	
INCREASE (DECREASE) IN NET ASSETS	**(3,147,155)**	**(3,600,207)**	**(1,456,205)**	**(3,656,072)**	**(11,791,935)**	**303,298**
Total Margin	*-29.0%*	*-51.6%*	*-12.2%*	*-36.3%*		*0.6%*
EBIDTA	**(2,366,454)**	**(2,709,186)**	**(565,184)**	**(2,765,051)**	**(8,338,171)**	**3,840,718**

ESTES PARK HEALTH

Days Cash on Hand



Questions?

ESTES PARK HEALTH

555 Prospect Ave. | P.O. Box 2740 | Estes Park, CO 80517

CFO Report
1st Quarter 2020

Executive Summary

It has been a very eventful last few months, to say the least. On March 19th, the Governor issues an **Executive Order for the Temporary Cessation of All Elective and Non-Essential Surgeries and Procedures and Preserving Personal Protective Equipment and Ventilators in Colorado Due to the Presence of COVID-19**. This is consistent with the Governor's Stay at Home Order effective March 26th.

As a result, patients in need of hospital services has diminished by approximately 60% thru April 22nd. The Governor has declared an easing of these orders effective April 26th however it remains to be seen how quickly the local economy will begin to recover. Accordingly, the hospital financials are reflective of this significant loss of revenue. The month of March reflects a 31% decrease in Revenues and the Year to Date decrease of 11%. The month of April, thus far, is dramatically lower, around 65%.

1. Through the first quarter of 2020, EPH is reporting a Net Loss of ($3.1M) compared to Budgeted Net Loss of ($1.6M). Prior period in 2019 reported a Net Loss of ($1.1).
2. Gross Patient Revenues are $2.3M under Budget, or 11% and $1.8M or 8% lower than last year.
3. Contractual Adjustments, as a percentage of gross revenue are slightly better than budget.
4. Expenses are close to budget, yet 17% higher than last year, due to Salaries, Contract Labor, Supplies and Purchased Services.
5. Days in Accounts Receivable are rebounding from the Epic conversion in November; from a high of 64 to a current 53. We expect this trend to continue.
6. Days Cash on Hand are down substantially to 132, due to the use of Cash for the Epic/Lawson conversion, the loss of the Sterilizer for 5 months, and the dramatic impact of the loss of business.

Revenues

Year to Date Inpatient Days and Revenues were substantially below budget by $2.1M. Outpatient visits are also reporting slightly below budget for the month. Unfortunately, visits are dramatically worse for April. There is some hope, however, with the easing of restrictions, that visits and revenues will begin to recover in May and June. Looking forward, the prevailing thought suggests a potential recovery of up to 50%, through the summer.

Expenses

Expenses continue to remain close to Budget. Senior Leadership did recommend a holding period through April to assess a potential surge in patient visits, as a result of COVID-19. To date, that has not materialized. Accordingly, discussions are underway with respect to Strategy for the next few months.

Statistics

	YTD	*Budget*	*2019*
Inpatient Days	163	235	273
Swing Bed	87	122	83
Births	12	21	18
ER Visits	1,066	1,025	1,025
Ambulance Trips	418	410	410
Clinic Visits	5,160	5,194	7,513
Surgeries (not incl GI)	156	210	176
GI Procedures	120	104	71
Lab Tests	16,338	17,589	17,589
Radiology Exams	2,352	2,512	2,512
Rehab Visits	2,083	2,611	2,780
Home Health/Hospice	2,306	2,314	2,371
Living Center Days	2,985	3,420	3,285

Balance Sheet

The Balance Sheet has certainly looked better than it does now. Unfortunately, it would appear there remain numerous challenges for the hospital. Cash is down considerably, due principally to the Epic/Lawson conversion and the Urgent Care Center, as well as declining Revenues. Days Cash on Hand are quite low at 132, yet still marginally good, given the current environment. Accounts Receivable continue to improve.

Forecast for 2020

Please note an attached Forecast and Assumptions (last two pages of this report). The numbers are indeed staggering. Working concurrently with our Audit firm and their toolkit, we have tried to develop a realistic look at the remainder of the year. Some assumptions were made regarding recovery of Revenues and some Expense reductions. However, given the dramatic and sudden loss of patient visits in April and likely May, and the potential of a very slow recovery, the impact is profound.

The good news is, while this Forecast does not include any funding received, the funds received as noted below are extremely helpful.

Funding Support

The District was successful in obtaining outside funding opportunities. However, at least half of the funds are designated as a loan and due to be repaid later this year. There is some hope that the Federal Government will designate those funds as forgivable. But that is not confirmed.

As a result of the recent support from the Federal Government, via several programs have provided funding in April:

- Advance Payment Program $4.4M
  -currently scheduled for repayment; possibility of forgiveness

- HHS Stimulus $702K
  -forgivable

- Payroll Protection Program $4.8M (approved; pending receipt)
  -eligible for forgiveness assuming compliance with stipulations.

Summary

Obviously, the remainder of the year does not look overly optimistic, with respect to Cash Flow. The good news is that we do have some funding completed to help navigate the next few difficult months. Cash reserves will be impacted as the months of cash payments, of June through August, have little volume. We have been working with our Audit firm (CliftonLarsonAllen, LLP) to model some financial assumptions with respect to Revenues, Expenses, Earnings and Cash Flow and the impact to our Days Cash on Hand ratio. We do believe sufficient funds exist, given a modest economic growth and good cash management. It is highly unlikely the District will accomplish the budgetary goals for the year, due specifically to the COVID-19 pandemic. The goal for the remainder of the year is to maintain sufficient cash flow in order to stay compliant with our covenants.

Estes Park Health

Financial Overview

Month Ended March 31, 2020

FINANCIAL RATIOS

	Feb	Mar	RED	YELLOW	GREEN
Days in Accounts Receivable	58.2	53.1	> 60	50 - 60	< 50
Days Cash on Hand	138	132	< 125	125 - 224	> 225
Debt Service Coverage Ratio	1.18	0.43	<1.25	1.25 - 2.0	> 2.0
Operating Margin (12 Mo. Rolling)	-8.3%	-11.0%	< 2.0%	2% - 4.99%	> 5%
Total Margin (12 Mo. Rolling)	-1.6%	-4.2%	< 5.0%	5% - 9.99%	> 10.0%

OTHER INDICATORS

	Feb	Mar	Budget	YTD	YTD Budget
Total Deductions from Revenue %	40.9%	42.0%	46.0%	44.4%	46.0%
Operating Margin	($749,994)	($2,193,710)	($847,798)	($3,940,551)	($2,538,744)
Operating Margin %	-17.4%	-71.5%	-21.0%	-36.3%	-21.4%
Increase (decrease) in Net Assets	($489,054)	($1,935,472)	($464,639)	($3,147,153)	($1,589,267)
Total Margin %	-11.3%	-63.0%	-11.5%	-29.0%	-13.4%

SUMMARY

Statistics: IP Days are at 54 compared to 115 in February and 140 in March 2019.
Physicians Clinic Visits are at 1271 compared to 1722 in February and 1703 in March 2019.
Surgeries are at 23 compared to 43 in February and 27 in March 2019.

Revenue: March's Gross Patient Revenue is $5,214,132 compared to a budget level of $7,336,771.

Other Operating Revenue: YTD Other Revenues are $90,120 below budget.

Expenses: Total Operating Expenses in March are $389,063 over budget. Salaries and benefits are under budget by $105,203.

Excess Revenues (Expenses): March's increase in Net Assets is -$1,935,472 compared to a budget of of -$464,639. March's Total Margin is -63% compared to a budgeted level of -11.5%.

Ratio Analysis: Day's in A/R is at 53.1 which is higher than the industry average of fifty.
Day's Cash on Hand is at 132 compared to February's level of 138 and March 2019 of 177.

Debt Coverage Ratio: March's rolling 12 month ratio is 0.42%. The loan end of year minimum required ratio is 1.25.

ESTES PARK HEALTH
Statement of Revenues and Expenses (Unaudited)
March 31, 2020

REVENUE	MONTH Mar-20 Actual	MONTH Mar-20 Budget	MONTH Mar-20 Var	YEAR TO DATE FY 2020 Actual	YEAR TO DATE FY 2020 Budget	YEAR TO DATE FY 2020 Var	PRIOR YEAR TO DATE FY 2019 Actual	PRIOR YEAR TO DATE FY 2019 Var
Patient Revenue								
In-Patient	$ 671,102	$ 1,845,532	-64%	$ 3,029,481	$ 5,134,312	-41%	$ 5,236,486	-42%
Out-Patient	4,543,031	5,491,239	-17%	16,279,271	16,468,107	-1%	15,854,693	3%
TOTAL PATIENT REVENUE	5,214,132	7,336,771	-29%	19,308,752	21,602,419	-11%	21,091,179	-8%
Less Contractual Adjustments	(2,462,711)	(3,301,547)	25%	(8,894,591)	(9,721,089)	9%	(10,344,367)	14%
Less Bad Debt Adjustments	273,915	(73,368)	473%	331,040	(216,025)	253%	(64,858)	610%
TOTAL REVENUE DEDUCTIONS	(2,188,796)	(3,374,915)	35%	(8,563,551)	(9,937,114)	14%	(10,409,225)	-18%
	42.0%	*46.0%*		*44.4%*	*46.0%*		*49.4%*	
NET PATIENT REVENUE	3,025,336	3,961,856	-24%	10,745,201	11,665,305	-8%	10,681,953	1%
Other Operating Revenue	44,454	77,041	-42%	118,863	208,983	-43%	173,514	-31%
TOTAL OPERATING REVENUE	3,069,790	4,038,897	-24%	10,864,063	11,874,288	-9%	10,855,467	0%
EXPENSES								
Wages	2,017,704	2,125,941	5%	6,069,131	6,192,266	2%	5,366,042	-13%
Benefits	588,194	585,160	-1%	1,560,727	1,528,953	-2%	1,601,742	3%
Contract Labor	780,690	526,418	-48%	1,850,442	1,578,554	-17%	1,592,219	-16%
Medical Supplies	425,106	374,997	-13%	1,360,464	1,120,874	-21%	1,138,451	-20%
Non-Medical Supplies	96,053	80,886	-19%	350,012	251,388	-39%	242,172	-45%
Purchased Services	593,088	576,394	-3%	1,789,162	1,817,782	2%	1,259,179	-42%
Other Operating Expenses	390,322	328,780	-19%	1,043,976	1,058,858	1%	905,536	-15%
Depreciation & Amortization	335,422	253,853	-32%	683,307	761,559	10%	500,196	-37%
Interest	36,921	34,266	-8%	97,394	102,798	5%	97,206	0%
TOTAL OPERATING EXPENSE	5,263,500	4,886,695	-8%	14,804,615	14,413,032	-3%	12,702,744	-17%
OPERATING INCOME (LOSS)	(2,193,710)	(847,798)	-159%	(3,940,551)	(2,538,744)	-55%	(1,847,277)	-113%
Operating Margin	*-71.5%*	*-21.0%*		*-36.3%*	*-21.4%*		*-17.0%*	
Non-Operating Revenue	262,433	287,559	-9%	805,983	862,677	-7%	786,257	3%
Non-Operating Expense	(4,195)	(4,400)	5%	(12,585)	(13,200)	5%	(12,582)	0%
EXCESS REVENUES (EXPENSES)	(1,935,472)	(564,639)	-243%	# (3,147,153)	(1,689,267)	-86%	(1,073,602)	193%
Gift to Purchase Capital Assets		100,000			100,000		15,277	
INCREASE (DECREASE) IN NET ASSETS	(1,935,472)	(464,639)	-317%	(3,147,153)	(1,589,267)	-98%	(1,058,325)	-197%
Total Margin	*-63.0%*	*-11.5%*		*-29.0%*	*-13.4%*		*-9.7%*	
EBDITA	$ (1,563,129)	$ (176,520)	-786%	$ (2,366,452)	$ (724,910)	-226%	$ (1,249,875)	

ESTES PARK HEALTH
Balance Sheet (Unaudited)
March 31, 2020

ASSETS	2020 Mar	2020 Feb
CASH & CASH EQUIVALENTS	$ 16,834,662	$ 17,367,265
PATIENT ACCOUNTS RECEIVABLE	11,257,627	13,759,900
LESS: ALLOWANCES	(5,508,872)	(6,651,276)
NET ACCOUNTS RECEIVABLE	5,748,755	7,108,624
RECEIVABLES FROM OTHER PAYORS	2,957,128	3,592,812
INVENTORY	1,076,941	1,075,458
PREPAID EXPENSES	600,863	321,605
TOTAL CURRENT ASSETS	**27,218,349**	**29,465,765**
NET PROPERTY, EQUIPMENT & INTANGIBLE ASSETS	**33,056,692**	**31,683,091**
RESTRICTED ASSETS	**1,413,976**	**1,413,563**
OTHER ASSETS	0	0
LONG TERM INVESTMENTS	1,040,820	754,840
TOTAL OTHER ASSETS	**1,040,820**	**754,840**
TOTAL ASSETS	**$ 62,729,837**	**$ 63,317,260**
LIABILITIES		
ACCOUNTS PAYABLE	1,425,755	952,534
ACCRUED EXPENSES	4,687,677	4,861,857
ACCRUED COMP PAYABLE	1,079,156	1,102,333
ACCRUED INTEREST PAYABLE	89,603	59,079
EST THIRD-PARTY SETTLEMENT	1,430,484	1,404,005
SHORT TERM NOTES PAYABLE	316,581	0
OTHER CURRENT LIABILITIES	0	0
CURRENT MATURITIES OF OTHER LONG TERM DEBT	1,085,000	1,085,000
TOTAL CURRENT LIABILITIES	**10,114,256**	**9,464,808**
DEPOSITS AND DEFERRED INCOME		
LOANS PAYABLE	13,098,651	12,400,000
LEASES PAYABLE	0	0
TOTAL LONG-TERM LIABILITIES	**13,098,651**	**12,400,000**
TOTAL LIABILITIES	**23,212,907**	**21,864,808**
INVESTED IN CAPITAL ASSETS, NET OF RELATED DEBT	42,664,083	42,664,133
UNRESTRICTED		
TOTAL NET ASSETS	**42,664,083**	**42,664,133**
EXCESS REVENUES YTD	**(3,147,153)**	**(1,211,681)**
TOTAL LIABILITIES & NET ASSETS	**$ 62,729,837**	**$ 63,317,260**

ESTES PARK HEALTH
Statistical and Consolidated Financial Summary
Month Ended March 31, 2020

	Month			Year To Date		
Utilization	**Actual**	**Budget**	**Variance To Budget**	**Actual**	**Budget**	**Variance To Budget**
Hospital						
In-Patient Days	54	175	-69.1%	300	439	-31.7%
Out Patient Visits	5622	6898	-18.5%	20655	21363	-3.3%
Living Center						
Resident Days	933	1178	-20.8%	2985	3420	-12.7%
Clinic						
Physicians Clinic Visits	1271	1852	-31.4%	5160	5194	-0.7%

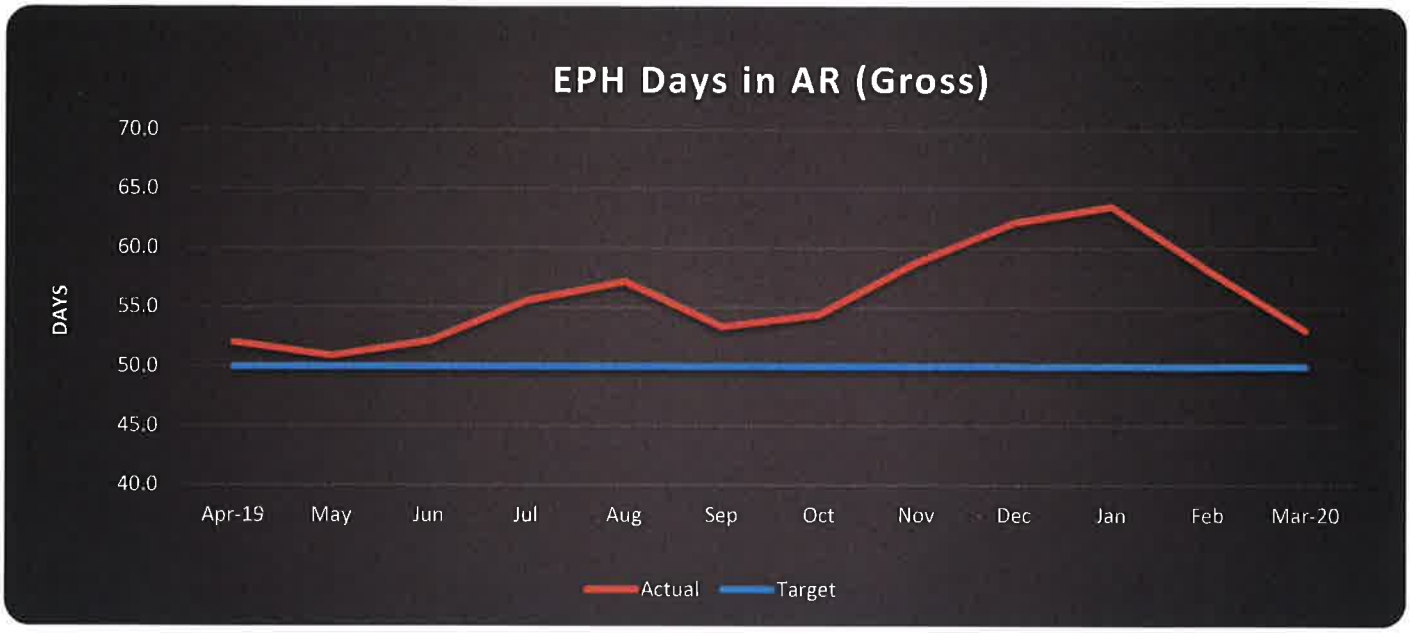
	Month				Year To Date			
Income Statement	**Actual**	**Budget**	**To Budget**	**% Variance**	**Actual**	**Budget**	**To Budget**	**% Variance**
Hospital								
Operating Revenue (Net)	$ 2,152,742	$ 2,783,234	(630,492)	-22.7%	$ 7,704,046	$ 8,236,110	(532,064)	-6.5%
Operating Expenses	3,857,842	3,575,617	(282,225)	-7.9%	10,617,344	10,583,445	(33,899)	-0.3%
Net Operating Income (Loss)	(1,705,100)	(792,383)	(912,717)	115.2%	(2,913,298)	(2,347,335)	(565,963)	-24.1%
Living Center								
Operating Revenue (Net)	280,723	388,844	(108,121)	-27.8%	976,930	1,129,959	(153,029)	-13.5%
Operating Expenses	457,412	417,162	(40,250)	-9.6%	1,299,157	1,224,360	(74,797)	-6.1%
Net Operating Income (Loss)	(176,689)	(28,318)	(148,371)	-523.9%	(322,227)	(94,401)	(227,826)	-241.3%
Clinic								
Operating Revenue (Net)	636,325	866,819	(230,494)	-26.6%	2,183,087	2,508,219	(325,132)	-13.0%
Operating Expenses	948,246	893,916	(54,330)	-6.1%	2,888,114	2,605,227	(282,887)	-10.9%
Net Operating Income (Loss)	(311,921)	(27,097)	(284,824)	-1051.1%	(705,027)	(97,008)	(608,019)	-626.8%
Total								
Operating Revenue (Net)	3,069,790	4,038,897	(969,107)	-24.0%	10,864,063	11,874,288	(1,010,225)	-8.5%
Operating Expenses	5,263,500	4,886,695	(376,805)	-7.7%	14,804,615	14,413,032	(391,583)	-2.7%
Net Operating Income (Loss)	(2,193,710)	(847,798)	(1,345,912)	-158.8%	(3,940,551)	(2,538,744)	(1,401,808)	-55.2%
Total								
Non Operating Revenue (Net)	262,433	287,359	(24,926)	-8.7%	805,983	862,677	(56,694)	-6.6%
Non Operating Expenses (Net)	(4,195)	(4,200)	5	0.1%	(12,585)	(13,200)	615	4.7%
Excess of Rev over Exp Before Cap gifts	$ (1,935,472)	$ (564,639)	$(1,370,833)	242.8%	$ (3,147,153)	$ (1,689,267)	$(1,457,886)	86.3%
Gifts to Purchase Capital Assets	-	100,000	(100,000)	-100.0%		100,000	(100,000)	-100.0%
Increase (Decrease) in Net Assets	$ (1,935,472)	$ (464,639)	$(1,470,833)	-316.6%	$ (3,147,153)	$ (1,589,267)	$(1,557,886)	-98.0%

ESTES PARK HEALTH

Statement of Cash Flows (Unaudited)

1/1/20 through 3/31/20

Cash Flows From Operating Activities	
(Deficiency) Excess of Revenues over Expenses	$ (3,147,153)
Interest expense (considered financing activity)	97,394
County tax subsidy, net (considered financing activity)	(749,364)
Interest income (considered investing activity)	44,034
Net income (loss) from operating activities	(3,755,089)
Assets released from restrictions	-
Depreciation & amortization	683,307
Changes in working capital:	
Decrease (Increase) in Accounts receivable, net	1,731,003
Decrease (Increase) in Inventory	19,465
Decrease (Increase) in Prepaid expenses	44,919
Decrease (Increase) in Other Assets	-
Decrease (Increase) in Long Term Investment	(286,840)
Increase (Decrease) in Accounts payable	86,977
Increase (Decrease) in Accrued wages & related liabilities	(256,050)
Increase (Decrease) in Other current liabilities	79,195
Increase (Decrease) in Deposits and Deferred Income	(1,054)
Increase (Decrease) in Payable to 3rd party payors	26,479
Net (gain) loss on sale of equipment	-
Net cash provided by (used in) operating activities	(1,627,688)
Cash Flows From Financing Activities	
Restricted contributions	-
County tax subsidy, net	749,364
Interest expense	(97,394)
Sale of equipment	-
Purchase of property, equipment & intangible assets	(2,491,192)
Increase (Decrease) in capital lease commitments, net	-
Loan Activity	1,015,232
Net cash provided by (used in) financing activities	(823,990)
Cash Flows From Investing Activities	
Interest income	(44,034)
Net cash provided by (used in) investing activities	(44,034)
Net Increase (Decrease) in Cash and Cash Equivalents	(2,495,711)
Cash and Cash Equivalents, 01/01/2020	20,744,349
Cash and Cash Equivalents, 3/31/20	$ 18,248,638
Restricted Cash and Cash Equivalents, 3/31/20	$ 1,413,976
Unrestricted Cash and Cash Equivalents, 3/31/20	16,834,662
	$ 18,248,638



Calculation: Gross Accounts Receivable / Average Daily Revenue

Definition: Considered a key "liquidity ratio" that calculates how quickly accounts are paid.

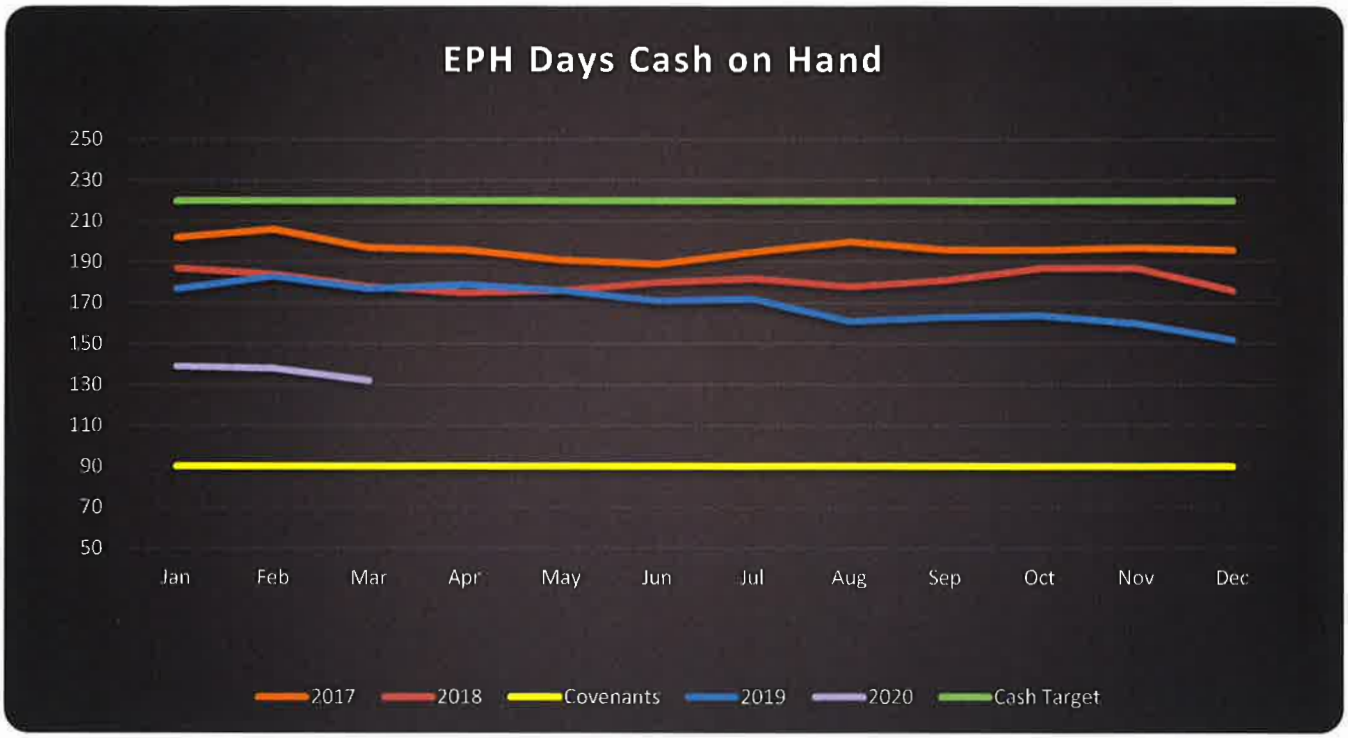
Desired Position: Downward trend below the median, and below average.

How ratio is used: Used to determine timing required to collect accounts. Usually, organizations below the average Days in AR are likely to have higher levels of Days Cash on Hand.

	Apr-19	May	Jun	Jul	Aug	Sep
A/R (Gross)	11,715,714	11,823,575	12,635,331	15,365,170	16,601,424	15,378,349
Days in Month	30	31	30	31	31	30
Monthly Revenue	6,946,431	7,675,605	7,410,739	10,356,792	8,951,469	7,200,698
Daily Revenue	225,023	232,239	242,118	276,556	290,424	288,141
Days in AR	**52.1**	**50.9**	**52.2**	**55.6**	**57.2**	**53.4**

	Oct	Nov	Dec	Jan	Feb	Mar-20
A/R (Gross)	14,173,824	13,806,401	14,575,357	14,237,980	13,759,900	11,257,627
Days in Month	31	30	31	31	29	31
Monthly Revenue	7,808,340	6,340,531	7,414,874	6,856,115	7,238,504	5,214,133
Daily Revenue	260,440	234,611	234,389	224,038	236,368	212,184
Days in AR	**54.4**	**58.8**	**62.2**	**63.6**	**58.2**	**53.1**

ESTES PARK HEALTH
Days Cash on Hand
March 31, 2020



Calculation: Total Unrestricted Cash on Hand / Daily Operating Cash Needs

Definition: This ratio quantifies the amount of cash on hand in terms of how many "days" an organization can survive with existing cash reserves.

Desired Position: Upward trend, above the median--AND above Bond Covenant Minimums

How ratio is used: This ratio is frequently used by bankers, bondholders and analysts to gauge an organization's liquidity--and ability to meet short term obligations as they mature.

Note: At EPH, the Bond Refunding/Loan documents require a minimum level of 90 days cash be maintained. It changed to 90 effective March 1, 2016.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	139	138	132									
2019	177	183	177	179	176	171	172	161	163	164	160	152
2018	187	184	178	175	176	180	182	178	181	187	187	176
2017	202	206	197	196	191	189	195	200	196	196	197	196
Bond Covenant MIN	90	90	90	90	90	90	90	90	90	90	90	90
Cash Target	220	220	220	220	220	220	220	220	220	220	220	220

ESTES PARK HEALTH
Statement of Revenues and Expenses (Unaudited)
Forecast 2020

	FISCAL YEAR 2019 Unaudited		YEAR TO DATE 1st Qtr 2020			FORECAST FY 2020						
REVENUE	**Actual**	**Budget**	**Actual**	**Budget**	**Var**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**FY 2020 Forecast**	**Budget 2020**	**Variance**	**% Variance**
Patient Revenue												
In-Patient	17,041,486	$ 18,982,874	3,029,481	5,134,312	-41%	2,436,498	3,795,374	3,588,309	12,849,662	19,985,112	(7,135,450)	-35.7%
Out-Patient	74,155,170	$ 74,847,893	16,279,271	16,468,107	-1%	9,811,456	17,068,838	13,972,570	57,132,134	77,722,701	(20,590,567)	-26.5%
TOTAL PATIENT REVENUE	91,196,656	93,830,767	19,308,751	21,602,419	-11%	12,247,953	20,864,212	17,560,878	69,981,796	97,707,813	(27,726,017)	-28.4%
Less Contractual Allowances	(41,787,005)	(42,573,741)	(8,894,591)	(9,721,089)	9%	(5,144,140)	(8,762,969)	(7,375,569)	(29,392,354)	(43,968,516)	14,576,162	-33.2%
Less Patient Uncollectable Allowa	(1,071,462)	868,852	331,040	(216,025)	253%	(244,959)	(417,284)	(351,218)	(1,399,636)	(977,078)	(422,558)	43.2%
TOTAL REVENUE DEDUCTIO	(42,858,467)	(43,442,593)	(8,563,551)	(9,937,114)	14%	(5,389,099)	(9,180,253)	(7,726,786)	(30,791,990)	(44,945,594)	14,153,604	-31.5%
			0	*46.0%*		*44.0%*	*44.0%*	*44.0%*	*44.0%*	*46.0%*		0.0%
NET PATIENT REVENUE	48,338,189	50,388,174	10,745,200	11,665,305	-8%	6,858,854	11,683,959	9,834,092	39,189,806	52,762,219	(13,572,413)	-25.7%
Other Operating Revenue	728,242	875,430	118,863	208,983	-43%	118,863	250,000	250,000	737,726	988,559	(250,833)	-25.4%
TOTAL OPERATING REVENUE	49,066,430	51,263,604	10,864,062	11,874,288	-9%	6,977,716	11,933,959	10,084,092	39,927,532	53,750,778	(13,823,246)	-25.7%
EXPENSES												
Wages	23,027,643	22,538,636	6,069,131	6,192,266	2%	5,677,586	6,308,429	6,308,429	24,363,576	25,117,554	(753,978)	-3.0%
Benefits	5,856,277	5,559,409	1,560,727	1,528,953	-2%	1,580,401	1,756,001	1,756,001	6,653,131	6,796,957	(143,826)	-2.1%
Contract Labor	6,548,453	6,473,841	1,850,442	1,578,554	-17%	1,114,904	1,592,721	1,592,721	6,150,788	6,356,716	(205,928)	-3.2%
Medical Supplies	4,347,458	4,316,834	1,360,464	1,120,874	-21%	787,304	1,124,720	1,124,720	4,397,209	4,495,035	(97,826)	-2.2%
Non-Medical Supplies	1,240,040	968,826	350,012	251,388	-39%	175,707	251,009	251,009	1,027,737	1,004,416	23,321	2.3%
Purchased Services	5,447,478	5,477,497	1,789,162	1,817,782	2%	1,240,355	1,378,172	1,378,172	5,785,862	5,952,299	(166,437)	-2.8%
Other Operating Expenses	3,443,496	3,643,125	1,043,976	1,058,858	1%	369,187	946,632	946,632	3,306,427	3,898,755	(592,328)	-15.2%
Depreciation & Amortization	2,081,217	2,230,460	683,307	761,559	10%	788,223	788,223	788,223	3,047,976	3,126,228	(78,252)	-2.5%
Interest/Bank Fees	395,453	411,187	97,394	102,798	5%	102,798	102,798	102,798	405,788	411,192	(5,404)	-1.3%
TOTAL OPERATING EXPENSE	52,387,515	51,619,815	14,804,615	14,413,032	-3%	11,836,466	14,248,707	14,248,707	55,138,494	57,159,152	(2,020,658)	-3.5%
OPERATING INCOME (LOSS)	**(3,321,085)**	**(356,211)**	**(3,940,553)**	**(2,538,744)**	**55%**	**(4,858,750)**	**(2,314,748)**	**(4,164,615)**	**(15,210,962)**	**(3,408,374)**	**(11,802,588)**	**-346.3%**
Operating Margin	*-6.8%*	*-0.7%*	*-36.3%*	*-21.4%*		*-69.6%*	*-19.4%*	*-41.3%*	*-38.1%*			
Non-Operating Revenue	3,308,333	2,990,000	805,983.00	862,677	-7%	871,128	871,128	521,128	3,069,367	3,484,512	(415,145)	-11.9%
Non-Operating Expense	(45,887)	(71,990)	(12,585)	(13,200)	5%	(12,585)	(12,585)	(12,585)	(50,340)	(72,840)	22,500	-30.9%
EXCESS REVENUES (EXPENSES)	(58,639)	2,561,799	(3,147,155)	(1,689,267)	86%	(4,000,207)	(1,456,205)	(3,656,072)	(12,191,935)	3,298	(12,195,233)	
Gift to Purchase Capital Assets	102,095	0	-	100,000		400,000	-	-	400,000	300,000	100,000	33.3%
INCREASE (DECREASE) IN NET ASSETS	**43,456**	**2,561,799**	**(3,147,155)**	**(1,589,267)**	**98%**	**(3,600,207)**	**(1,456,205)**	**(3,656,072)**	**(11,791,935)**	**303,298**	(12,095,233)	
Total Margin	*0.1%*	*5.0%*	*-29.0%*	*-13.4%*		*-51.6%*	*-12.2%*	*-36.3%*		*0.6%*		
EBIDTA	**2,520,126**	**5,203,446**	**(2,366,454)**	**(724,910)**		**(2,709,186)**	**(565,184)**	**(2,765,051)**	**(8,338,171)**	**3,840,718**		

Estes Park Health

Assumptions - Forecast thru the COVID-19 Event

Apr-20

	May/June	3rd Qtr	FY 2020
Revenues	March '20 saw a 31% decline in Revenues, across the board. Accordingly 3rd Qtr results showed an 11% loss of Revenues. Notably in Medsurg, Emergency Dept, Surgery, Radiology, Lab and Rehab. Expectations for April are approx 40% decline in Revenues With the potential of a change in "Stay at Home" restrictions, EPH could potentially see a gradual increase in patient visits, currently estimated about 5% per week. Resulting in potentially up to 50% of average (defined as budget) by end of June.	As time progresses thru the summer, and if luck holds up, expectations could yield a potential recovery of 70% by end of September.	By end of year, expectation (and hope) could allow for a continued 80% of average by end of the year.
Expenses	Through April, expenses are expected to remain normal, as was the promise to the staff. Funds are promised to cover payroll for an 8 week period. Other spending is closely monitored. For May and June, expectations are to reduce Salary costs by up to 10%, including several initiatives. Contract Labor, other than Pediatric Call, is expected to be eliminated.	For July thru September, with Revenues anticipated at 70% of normal, the hospital will try to keep expenses at 80%. However forecasting budgeted expense	The same for year end, if Revenues are 80% recovery, so should Expenses.
Earnings	The first quarter is reporting a net loss of $3M. April thru June (2nd Qtr) is expecting further loss.		Year end expectations for net loss are between $5M and 7M.
Cash Flow	Loss of Cash thru March is $2M	Thru September Cash is expected to decrease by $5M.	End of year is expecting Days Cash on Hand to be aroun 125.
Impact of Stimulus Funds	Thru April 22, total funds received from Medicare and other Stimulus programs is $5.1M. However, as of this report, $4.4M must be repaid over 5 months beginning in August. There are efforts underway to request these funds be forgivable. Pending. The hospital was successful in obtaining a forgivable loan from the CARES Act and the Payroll Protection Program of $4.8M. Expected receipt is early in the week of April 27. This is specifically for covering Payroll costs for 8 weeks.	With an added infusion of $10M in cash, availability should not be a problem. However, much depends on the possibility of having to repay $4.4M.	Assuming a repayment of the $4.4M, and the Revenue and Expense projections are close, cash as end of the year will likely show a net loss of $4M, thus reducing Days Cash on Hand to somewhere near 120 days.

Park Hospital District Board
Timberline Conference Room
April 27, 2020

CREDENTIALING RECOMMENDATIONS

Credentials Committee approval: March 19, 2020
Present: Drs. Zehr (Chair), Florence, Meyer, Bill Pinkham, and Andrea Thomas
Via conference call: Monty Miller

Medical Executive Committee approval: April 1, 2020

Reappointments

Baird, Kristin, M.D.	Courtesy, Dermatology
Daley, Chris, M.D.	Active, Emergency Medicine
Florence, Aaron, D.O.	Active, Orthopedic Surgery
Green, C. Patrick, M.D.	Courtesy, Cardiology
Wahl, W. Brent, M.D.	Courtesy, Diagnostic Radiology