Strategic Assessment
August, 2006

STROUDWATER ASSOCIATES
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Study Charge and Context

The charge of this planning study funded by the Telluride Medical Capital Fund is to develop a long-term strategic direction for the Telluride Medical Center (TMC), coupled with a concrete business and financial plan detailing specific directions and next steps for effectively pursuing the vision.

Following TMC’s termination of its management contract with Montrose Memorial Hospital in 2003, TMC was in a position of needing to re-establish an operating, financial, and management infrastructure from the ground up. Part of the tactical response by the Board was to bring in an interim contract management capacity, and to contract out for billing services. In addition to improving financial and management processes, part of the rationale for the split with Montrose was to establish sufficient autonomy to define TMC’s future directions from a community perspective.

An early step in the process of developing a future vision for TMC was the completion of a needs assessment by the Telluride Foundation in the spring of 2004. Among the findings of this study were the following:

TMC was rated highest in terms of location, quality of emergency and primary care, and quality of providers.

- TMC was rated lower in terms of hours of operation, range of services available, time spent waiting to see a provider, and transparency of billing and payment information.

- More than half (60%) of consumers reported leaving the area for specialty services, and 38% reported leaving the area for primary care or outpatient surgery services.

- The majority of consumers (72%) are supportive of using tax dollars to support TMC, and 66% were supportive of additional tax assessments to offer more services at TMC.

- The services most frequently identified in the study as needing additional local capacity were, in order of priority, pediatric services, orthopedic services, behavioral health services, birthing, cardiology, and ambulatory surgery.

- Consumers are pleased with TMC’s existing location, but would pick a
Society Turn location if an alternative site is pursued.

Informed by this needs assessment, the following study is aimed at creating a clear vision for how needs can be addressed within a viable, sustainable business model.

The approach to answering this question was to review TMC’s current environment using public data, site visits and interviews, review its current operating and financial status, develop a vision for a TMC that effectively addresses some of the themes identified in the needs assessment, and develop a business model for how this vision can be practically pursued.

The study process was guided by a Telluride Medical Economic Assessment Advisory Committee that is comprised of the following individuals:

Dr. Peter Hackett, TMC Staff  
Becky Padilla, TMC Staff  
Gary Hughes, TMC Staff  
Bill Grun, Telluride Hospital District Board member  
Dr. Rick Houck, Telluride Medical Capital Fund member  
Davis Fansler, Mayor of the Town of Mountain Village  
John Pryor, Mayor of the Town of Telluride  
Elaine Fischer, San Miguel County Commissioner  
Dr. David Homer, local private practitioner

The Advisory Committee provided only two guiding assumptions to this study:

1. The study was to assume that any recommendations requiring development of a new facility would not be implemented for at least five years.

2. If recommendations included a change in location of a TMC facility, it should be assumed that the associated real estate costs would be addressed via philanthropy.

The Advisory Committee was explicit in its intent that the findings and recommendations of this study were to be the independent conclusions of the consultants, and were not expected to necessarily reflect the opinions of the Advisory Committee or any of its individual members. While the Advisory Committee’s input to this study was invaluable, it was advisory only, and the findings and recommendations represent the independent opinion of Stroudwater Associates.
Summary of Key Findings and Recommendations

The following points reflect the judgment of the consultants regarding those points presented and documented in the remainder of the report that are of particular importance in providing direction to subsequent decisions regarding the future of Telluride Medical Center.

It is worth noting that only a subset of the following recommendations are independent of issues related to the current facility. Recommendations related to new services and capabilities are dependent upon questions related to the current facility and its functional limitations being resolved.

The following recommendations can be evaluated independently of issues related to Telluride Medical Center’s facility.

1. TMC should begin to prepare and submit cost reports in recognition of its existing Rural Health Center (RHC) status. This should include any retrospective cost reports that the Medicare/Medicaid Financial Intermediary will accept for prior years. This is estimated to generate approximately $17,000/year in incremental revenue.

2. The Community Clinic (CC) practice should remain an employed model in order to achieve the financial benefits of provider-based RHC status. However, an incentive compensation plan should be established by 2007 that allows TMC to provide this service on a financial break-even basis. This can be accomplished by equitably allocating overhead to each physician provider, and allowing each physician to keep all cash receipts above their allocated overhead expense.
   
   a. TMC would have the incentive to keep overhead at or below market levels and contract-based and RHC revenue above private practice levels given the options available to the current primary care medical staff either to leave or set up an independent private practice
   
   b. The primary care physicians will have to determine how best to address the market’s desire for continuity of care.

3. The procedure oriented specialties of orthopedic surgery, general surgery, plastic surgery, podiatry, gynecologic surgery, anesthesia, ENT surgery, urology, and gastroenterology should be actively encouraged to join the TMC medical staff and schedule clinic time. These specialties have minimal impact on primary care service volumes, and become a basis for achieving procedure volumes for a TMC ambulatory surgery center service, especially if they are included as investment partners with TMC.

4. Medical specialists such as pediatrics, neurology, cardiology, dermatology, allergy, rheumatology, endocrinology, oncology, etc.
should be invited to be privileged as medical staff members based upon the recommendation of the CC physicians.

5. Dr. Peter Hackett has established an international reputation as a research scientist in the area of high altitude medicine. TMC’s location at approximately 9,000 feet makes it a valuable resource for supporting clinical research in this area. TMC should seek to continue to expand its role in supporting the work of Dr. Hackett and the University of Colorado in this endeavor. This brings a variety of advantages to TMC, including recruitment and retention of clinical staff, the potential for grant funding for acquiring capital equipment, the ability to host conferences, and the ability to build a stronger relationship with the Medical Center at the University of Colorado.

The recommendations below are directly related to or dependent upon resolution of questions related to TMC’s current facility.

1. TMC should acknowledge that its existing facility, which is leased for $1/year from the Idarado Mining Company, is inadequate to meet peak volumes that it currently experiences. Given the growth in volume that continues to occur it will become increasingly inadequate to address future patient volumes efficiently and safely. It currently falls well below contemporary clinical and support space standards of functionality and design.
   
a. Making major investments in a facility that is not owned and is poorly designed and sited to support future growth would represent a poor business decision for TMC.

2. A new facility should be located in a manner that acknowledges that it will serve as a resource for San Miguel County, and not only a resource of the Town of Telluride. A location at or near Society Turn would be logical.

3. The vision of a new facility and an expanded clinical service program should serve as the case for a significant capital campaign by TMC.

4. Existing local healthcare providers have expressed little enthusiasm to participate in a new medical center campus. Concern is primarily based on potential location and lease rates. A facility master plan should still anticipate that these attitudes will change once the initial development phase is successfully executed. It would be logical that pharmacy services, physical therapy services, and oxygen and other retail durable medical device services could be conveniently accessed at a single central location.

5. Assuming that a new TMC facility is developed on a new site, the campus plan should anticipate the ability to support Emergency Medical Services including garage space, dispatch, and a heliport for medical
evacuation on the site. This would create the opportunity to share some staffing responsibilities in the EC. It would also facilitate ongoing training and integrated planning. In the future, the business merit of shifting Emergency Medical Services from the Fire District to the Hospital District should also be studied from a functional and efficiency standpoint.

6. An MRI service should be actively pursued by TMC. This should be structured in a business model that seeks philanthropic support for the equipment and space required, and aligns the financial interests of key physician-based specialists and TMC. Both (a) an “under arrangements” business model that allows physicians to share in the technical fee component on a “per click” basis without any investment requirements, and (b) a physician–hospital leasing model that provides a return to physicians independent of referrals should be specifically reviewed.

7. An ambulatory surgery service should be carefully evaluated by TMC. A preliminary financial assessment suggests that there is sufficient volume to potentially achieve financial viability assuming significant market share can be achieved. A business model that provides philanthropic support for equipment and space and aligns the financial interests of key physicians significantly improves the potential for business success. Development of a business plan sufficient to support solicitation of physician investors will provide a clear test of business merit.

8. TMC should consider seeking federal Critical Access Hospital (CAH) designation. This recommendation would enable TMC to potentially achieve the following outcomes:

   a. Add limited overnight acute, observation, and skilled nursing level care. It is proposed that this be in the form of a 4-6 bed inpatient unit that would care for patients up to four days. However, it should not include obstetrics or other specialty services generally associated with larger community hospitals.

   b. It would require development of a new facility, making it possible to address the facility issues summarized in point #2 above.

   c. It would allow the RHC to become provider based, which allows for “un-capped” cost-based reimbursement. The annual incremental value of this is estimated to be a minimum of $17,000/year in additional revenue beyond that realized from utilizing TMC’s existing status as an RHC.

   d. It would provide a different platform for negotiating with all commercial payers, since the context will be hospital fee schedules vs. the existing clinic fee schedules that serve as the starting point for current contract discussions.

   e. It has the business potential to run profitability under a number of (but not all) service program scenarios. Its economic viability is maximized when services include MRI, ambulatory surgery, and rehabilitation services.
f. This represents a clear new vision for TMC that allows it to structure a community campaign in a manner that differentiates the future from the status quo.

g. Becoming a CAH does require the involvement of an acute care referral partner. Stroudwater believes that St. Mary’s in Grand Junction would be an ideal partner given its existing role as a trauma center and tertiary service provider as well as its history of working with smaller hospitals on the western slope of the Rockies. The breadth and depth if its affiliated specialist medical staff would also be a potential asset for specialty clinics and services at TMC, including the implementation of telemedicine services.
Environmental Assessment

TMC Profile
Telluride Medical Center (TMC) has served the residents of Telluride and surrounding communities since 1978. It is situated 60 miles and a mountain pass from the nearest hospital in Montrose, Colorado in an isolated but spectacular mountain valley.

<table>
<thead>
<tr>
<th>Name</th>
<th>City</th>
<th>State</th>
<th>Driving Mileage from Telluride</th>
<th>Drive Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southwest Memorial Hospital</td>
<td>Cortez</td>
<td>CO</td>
<td>75</td>
<td>1h 20m</td>
</tr>
<tr>
<td>Montrose Memorial Hospital</td>
<td>Montrose</td>
<td>CO</td>
<td>60</td>
<td>1h 37m</td>
</tr>
<tr>
<td>Animas Surgical Hospital</td>
<td>Durango</td>
<td>CO</td>
<td>71</td>
<td>1h 44m</td>
</tr>
<tr>
<td>Mercy Medical Center</td>
<td>Durango</td>
<td>CO</td>
<td>71</td>
<td>1h 44m</td>
</tr>
<tr>
<td>Delta County Memorial Hospital</td>
<td>Delta</td>
<td>CO</td>
<td>82</td>
<td>2h 4m</td>
</tr>
<tr>
<td>Community Hospital</td>
<td>Grand Junction</td>
<td>CO</td>
<td>122</td>
<td>2h 56m</td>
</tr>
<tr>
<td>St. Mary’s Hospital and Medical Center</td>
<td>Grand Junction</td>
<td>CO</td>
<td>122</td>
<td>2h 56m</td>
</tr>
<tr>
<td>San Juan Regional Medical Center</td>
<td>Farmington</td>
<td>NM</td>
<td>122</td>
<td>2h 47m</td>
</tr>
<tr>
<td>Gunnison Valley Hospital</td>
<td>Gunnison</td>
<td>CO</td>
<td>125</td>
<td>2h 56m</td>
</tr>
<tr>
<td>Family Health West</td>
<td>Fruita</td>
<td>CO</td>
<td>134</td>
<td>3h 9m</td>
</tr>
<tr>
<td>Aspen Valley Hospital District</td>
<td>Aspen</td>
<td>CO</td>
<td>184</td>
<td>4h 48m</td>
</tr>
</tbody>
</table>

Source: American Hospital Directory.com

TMC operates two patient care business units – the Emergency Clinic (EC), which provides emergency and urgent care services, and the Community Clinic (CC), which is comprised of TMC’s primary care practice. TMC offers family, preventive and emergency medicine. Clinical specialties include orthopedic care, sports medicine, and high altitude medicine. TMC is staffed by board certified Family Practice, Internal Medicine and Emergency Medicine physicians. Nationally certified nurse practitioners and physician assistants are joined by registered nurses and radiology technicians to provide patient care services. Ancillary services provided at TMC include the CT scanning, radiology, and laboratory diagnostic services.

In addition, numerous specialists conduct visiting clinics at TMC on a regular schedule. Orthopedics is the most frequent and highest volume set of specialty clinics. Other clinics include podiatry, cardiology, pain management, midwifery, urology, dentistry, general surgery and dermatology.

The Emergency Clinic provides emergency care on a 24/7 basis. These emergency services are partially funded via a tax district. In 2005, total tax support for the EC equaled $1.16M. The EC experiences seasonal fluctuations in patient volumes that are driven by peak ski season and by summer visitors. However, as the graph below demonstrates, peak demand is much more pronounced during the winter months with a smaller spike in the summer.
The following table details the EC’s patient volume by month for 2001 through 2005. Source: TMC.

<table>
<thead>
<tr>
<th>Month</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>AVG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>287</td>
<td>283</td>
<td>340</td>
<td>396</td>
<td>455</td>
<td>362</td>
</tr>
<tr>
<td>Feb</td>
<td>240</td>
<td>261</td>
<td>339</td>
<td>383</td>
<td>508</td>
<td>346</td>
</tr>
<tr>
<td>Mar</td>
<td>286</td>
<td>320</td>
<td>411</td>
<td>469</td>
<td>632</td>
<td>424</td>
</tr>
<tr>
<td>Apr</td>
<td>93</td>
<td>73</td>
<td>82</td>
<td>106</td>
<td>138</td>
<td>98</td>
</tr>
<tr>
<td>May</td>
<td>72</td>
<td>54</td>
<td>78</td>
<td>109</td>
<td>155</td>
<td>94</td>
</tr>
<tr>
<td>Jun</td>
<td>145</td>
<td>107</td>
<td>196</td>
<td>186</td>
<td>239</td>
<td>175</td>
</tr>
<tr>
<td>Jul</td>
<td>155</td>
<td>186</td>
<td>274</td>
<td>291</td>
<td>333</td>
<td>248</td>
</tr>
<tr>
<td>Aug</td>
<td>115</td>
<td>120</td>
<td>196</td>
<td>175</td>
<td>213</td>
<td>164</td>
</tr>
<tr>
<td>Sep</td>
<td>97</td>
<td>127</td>
<td>174</td>
<td>201</td>
<td>169</td>
<td>154</td>
</tr>
<tr>
<td>Oct</td>
<td>67</td>
<td>60</td>
<td>99</td>
<td>143</td>
<td>176</td>
<td>109</td>
</tr>
<tr>
<td>Nov</td>
<td>60</td>
<td>61</td>
<td>100</td>
<td>142</td>
<td>–</td>
<td>91</td>
</tr>
<tr>
<td>Dec</td>
<td>232</td>
<td>257</td>
<td>331</td>
<td>451</td>
<td>–</td>
<td>318</td>
</tr>
<tr>
<td>AVG</td>
<td>154</td>
<td>159</td>
<td>218</td>
<td>254</td>
<td>302</td>
<td>–</td>
</tr>
</tbody>
</table>

Volume in the EC has trended upward over the last five years. These increases in volume have not only occurred during peak periods but also during off-peak months as well. Minimum monthly patient volume has grown from 60 in 2001 to 138 in 2005, an increase of 130%. Peak monthly volume has grown from 287 in 2001 to 508 in 2005, an increase of 77%.
The chart below measures variability in monthly patient volumes in the EC based upon two indicators: the multiple of average to minimum monthly volume and the multiple of peak to minimum monthly volume. For 2001 to 2005, peak volume is 4.99 times minimum monthly volume while average monthly volume is 2.64 times minimum monthly volume. The month-to-month patient volume variability in the EC is as much as twice that experienced in the Community Clinic and more closely resembles Telluride’s seasonal fluctuation in visitors and economic activity.

For the Community Clinic or Family Practice, month-to-month and seasonal variability in patient volumes is less pronounced. There is a peak in demand during the winter months from December through March but this spike is much less pronounced than the seasonal peak demand experienced by the EC.
The table below details monthly patient volumes for the CC from 2001 to 2005.

<table>
<thead>
<tr>
<th>Month</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>AVG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>1083</td>
<td>1083</td>
<td>901</td>
<td>944</td>
<td>1098</td>
<td>1022</td>
</tr>
<tr>
<td>Feb</td>
<td>975</td>
<td>980</td>
<td>828</td>
<td>1087</td>
<td>969</td>
<td>972</td>
</tr>
<tr>
<td>Mar</td>
<td>1149</td>
<td>1204</td>
<td>939</td>
<td>1093</td>
<td>1109</td>
<td>1099</td>
</tr>
<tr>
<td>Apr</td>
<td>692</td>
<td>677</td>
<td>685</td>
<td>667</td>
<td>646</td>
<td>653</td>
</tr>
<tr>
<td>May</td>
<td>717</td>
<td>657</td>
<td>542</td>
<td>701</td>
<td>666</td>
<td>657</td>
</tr>
<tr>
<td>Jun</td>
<td>784</td>
<td>630</td>
<td>755</td>
<td>861</td>
<td>774</td>
<td>761</td>
</tr>
<tr>
<td>Jul</td>
<td>857</td>
<td>962</td>
<td>884</td>
<td>985</td>
<td>827</td>
<td>903</td>
</tr>
<tr>
<td>Aug</td>
<td>955</td>
<td>914</td>
<td>855</td>
<td>914</td>
<td>921</td>
<td>912</td>
</tr>
<tr>
<td>Sep</td>
<td>761</td>
<td>703</td>
<td>746</td>
<td>788</td>
<td>629</td>
<td>725</td>
</tr>
<tr>
<td>Oct</td>
<td>738</td>
<td>717</td>
<td>737</td>
<td>836</td>
<td>889</td>
<td>783</td>
</tr>
<tr>
<td>Nov</td>
<td>715</td>
<td>665</td>
<td>694</td>
<td>670</td>
<td>756</td>
<td>700</td>
</tr>
<tr>
<td>Dec</td>
<td>837</td>
<td>781</td>
<td>1152</td>
<td>1000</td>
<td>--</td>
<td>943</td>
</tr>
</tbody>
</table>

Volume in the CC has been flat since 2001, decreasing slightly between 2001 and 2005 based upon monthly average patient visit volume. Minimum monthly volumes have actually declined between 2001 – 2005 (692-629). Peak monthly volumes for the same period have likewise declined slightly from 1149 to 1109. These trends are described in the following chart.
The chart below measures variability in monthly patient volumes in the CC based upon two indicators: the multiple of average to minimum monthly volume and the multiple of peak to minimum monthly volume. For 2001 to 2005, peak volume is 1.77 times minimum monthly volume while average monthly volume is 1.28 times minimum monthly volume. In both instances, seasonal variability in the CC is less than half that experienced by the EC.

Stroudwater Associates believes that the average to minimum volume multiple is a suitable proxy for the demand that non-residents place on current TMC services. Using the average to minimum monthly volume multiple (2.64x for the EC and 1.28x for the CC) enables us to allow for the normal seasonal and random fluctuations that occur at all healthcare providers while quantifying the difference in seasonal variability between the EC and CC.

For purposes of forecasting demand for healthcare services and healthcare providers, Stroudwater has employed the above multiples to account for non-
resident demand for healthcare services. For services related to emergent conditions and sports activity-related injuries, Stroudwater Associates has assumed a 2.5x multiplier to reflect the impact of visitors and seasonal residents on the demand for services above and beyond that generated by the service area’s permanent residents. While a multiplier of 2.5x is lower than the five year average, this multiplier has trended down slightly from 2001 so Stroudwater has taken a more conservative approach in this case.

For other non-elective, urgent care services, Stroudwater has assumed a 1.3x multiplier to reflect the impact of seasonal and short-term visitors on these services. This multiplier reflects the seasonal average demand on the CC above its year-round minimum demand. For elective services, Stroudwater has assumed that there is no multiplier on the demand for healthcare services in Telluride from seasonal and short-term visitors. Later in the study, the potential for “medical tourism” for niche healthcare services will be discussed. Medical tourism would present an opportunity for TMC to realize volume from elective services provided to patients that reside almost exclusively outside Telluride’s service area.
TMC Service Area

Stroudwater Associates has developed a service area definition for TMC that reflects Telluride’s relative isolation and the specific realities of the area’s road network. The first step in defining TMC’s service area has been to conduct a drive time analysis for TMC and the Montrose Hospital in relation to key locations in the potential catchment area. A second component for defining the service area is to examine TMC’s patient origin.

As a result of these analyses and feedback from the Advisory Committee, Ouray, Norwood and Ridgeway have been dropped from TMC’s service area definition. To account for immigration from these areas, a 10% gross-up factor has been added to estimated service area demand to reflect demand for services at TMC from patients residing in these outlying areas. To account for non-permanent resident demand for services, Stroudwater has also added a multiple to service levels that accounts for peak season demand for emergent services (2.5x), urgent service (1.3x) and elective services (1.0x), respectively.

A map of the revised TMC service area is provided below.

![Map of TMC Service Area](source: ArcGIS)

As the green shaded area above indicates, the TMC service area is comprised of the eastern portions of San Miguel County. The TMC service area includes Telluride (81435), Ophir (81426) and Placerville (81430). Together, these communities comprise 47.3% of CC BCBS patients and 27.1% of EC BCBS patients. An additional 5.5% and 4.0% of TMC BCBS patients for the CC and EC, respectively, come from communities surrounding TMC’s service area.
This patient origin analysis indicates that 11.6% of TMC’s CC patients come from communities adjacent to the service area. The corresponding figure for the EC is 14.8%. Given this patient origin information, it would seem reasonable to conclude that 10% of CC patients come from communities adjacent to the TMC service area and 15% of EC patients come from communities adjacent to the TMC service area. The remaining balance of patients is generated by visitors and non-permanent residents.

The analysis of patient origin for TMC’s Blue Cross patients reveals that the EC and CC pull patients differently from within and outside the service area. The EC has a much larger proportion of Blue Cross patients from out of the area (68.9%) while the CC has a more concentrated patient origin pattern with a lower proportion of out-of-area patients (47.4%) that reflects visitors’ and commuters’ tendency to seek elective and preventive care closer to home and not while on vacation or at their second home. For the CC, 42.4% of Blue Cross patients are from Telluride versus 25.3% for the EC.

<table>
<thead>
<tr>
<th>Town</th>
<th>CC Blue Cross Patient Origin Patients</th>
<th>%CC Total</th>
<th>EC Blue Cross Patient Origin Patients</th>
<th>%EC Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telluride</td>
<td>430</td>
<td>42.4%</td>
<td>Telluride</td>
<td>57</td>
</tr>
<tr>
<td>Placerville</td>
<td>27</td>
<td>2.7%</td>
<td>Montrose</td>
<td>4</td>
</tr>
<tr>
<td>Norwood</td>
<td>26</td>
<td>2.6%</td>
<td>Norwood</td>
<td>2</td>
</tr>
<tr>
<td>Ophir</td>
<td>22</td>
<td>2.2%</td>
<td>Ophir</td>
<td>2</td>
</tr>
<tr>
<td>Ridgeway</td>
<td>12</td>
<td>1.2%</td>
<td>Placerville</td>
<td>2</td>
</tr>
<tr>
<td>Rico</td>
<td>7</td>
<td>0.7%</td>
<td>Ridgeway</td>
<td>2</td>
</tr>
<tr>
<td>Montrose</td>
<td>6</td>
<td>0.6%</td>
<td>Naturita</td>
<td>1</td>
</tr>
<tr>
<td>Ouray</td>
<td>3</td>
<td>0.3%</td>
<td>Ouray</td>
<td>0</td>
</tr>
<tr>
<td>Naturita</td>
<td>1</td>
<td>0.1%</td>
<td>Rico</td>
<td>0</td>
</tr>
<tr>
<td>Out of Area</td>
<td>481</td>
<td>47.4%</td>
<td>Out of Area</td>
<td>155</td>
</tr>
<tr>
<td>Total</td>
<td>1015</td>
<td>100.0%</td>
<td>Total</td>
<td>225</td>
</tr>
</tbody>
</table>

Source: TMC.

The following analysis provides a snapshot of TMC’s service area demographics. TMC’s service area includes Telluride, Placerville/Sawpith and Ophir. A striking feature of this 6,000+ population is the low proportion of senior citizens relative in the service area (2.9% in 2005) relative to the current national average (12.0%).

Another key demographic feature is that the market is growing. Projected growth between 2005 and 2010 is 12.4% and is viewed as unlikely to diminish in the decade or two that follow. A primary reason driving this assumption is that there remains additional residential build-out potential of nearly 100% beyond current levels in the combined areas of Lawson Hill, Aldasora, Ski Ranches, Mountain Village, and Telluride. [Source: Ron Allred]
A more detailed demographic analysis is included below for the TMC service area.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>00-17</td>
<td>979</td>
<td>1,121</td>
<td>142</td>
<td>14.50%</td>
</tr>
<tr>
<td>18-44</td>
<td>3,150</td>
<td>3,092</td>
<td>-58</td>
<td>-1.80%</td>
</tr>
<tr>
<td>45-64</td>
<td>1,730</td>
<td>2,149</td>
<td>419</td>
<td>24.20%</td>
</tr>
<tr>
<td>65+</td>
<td>177</td>
<td>423</td>
<td>246</td>
<td>139.00%</td>
</tr>
<tr>
<td></td>
<td>6,036</td>
<td>6,785</td>
<td>749</td>
<td>12.40%</td>
</tr>
</tbody>
</table>

Source: Solucient.
The maps below present the population and projected growth of the region by ZIP Code. These maps help place the TMC service area in the context of the larger region.

2004 Population of the Region by ZIP Code

2014 Population of the Region by ZIP Code
The residents of TMC’s service area create significant demand for healthcare services – even without inclusion of seasonal, vacationing and commuter populations. The table below highlights the demand for inpatient healthcare services. The number of inpatient stays generated by permanent residents of the TMC service area in 2005 is estimated at 249 and is projected to grow by 16.9% by 2010. Obstetrics related diagnoses accounted for 37.8% of inpatient cases, followed by orthopedics (14.9%), general surgery (8.0%), and gastrointestinal and pulmonology (4.8%). It is likely that the proportion of outpatient orthopedics cases for the TMC service area is far larger – given the relative youth of the population, active lifestyles, and sports related injuries.
Given the patient origin analysis conducted on TMC’s BCBS patients, we would expect an additional 10% of CC volume and 15% of EC volume to originate from adjacent surrounding areas. Accordingly, we would project between 10% to 15% additional volume for inpatient services in Telluride on top of the above volume estimates and projects from TMC’s service area.

Additionally, given that TMC will not offer an OB service, we need to calculate inpatient market share based upon non-OB volumes for TMC. The following table provides estimated inpatient volumes for TMC in 2010, assuming different rates on market penetration for non-OB service.

---

### 2010 Solucient Inpatient Demand Projection - TMC Service Area

<table>
<thead>
<tr>
<th></th>
<th>2010 TMC Admits</th>
<th>2010 TMC Admits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60% Share 50% Share 40% Share</td>
<td></td>
</tr>
<tr>
<td>TMC Service Area Admits</td>
<td>118</td>
<td>99</td>
</tr>
<tr>
<td>Less OB</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>Net Non-OB Admits</td>
<td>136</td>
<td>113</td>
</tr>
<tr>
<td>Inmigration from SSA</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>Area Admits to TMC</td>
<td>136</td>
<td>113</td>
</tr>
<tr>
<td>Transient / Seasonal Admits*</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>Total Est. TMC Admits</td>
<td>156</td>
<td>130</td>
</tr>
</tbody>
</table>

*Assumed to represent 15% of demand from permanent residents.

Adding a non-permanent resident gross-up factor of 15% indicates that we assume a 10% market share of inpatient emergent care for non-permanent
residents. Stroudwater has assumed a 150% gross-up or 2.5x multiplier for emergent care services demand in the EC when peak seasonal demand and transient visitors are included. The above demand projection for inpatient services assumes only a 15% gross-up factor, resulting in an assumed 10% share of non-permanent resident demand for inpatient care.

Inpatient market share for Medicare patients is depicted in the following table. Given its status as the nearest acute care hospital, it is not surprising that Montrose is the market leader for inpatient services within the combined TMC primary and secondary service areas. St. Mary’s in Grand Junction is the next most significant inpatient presence. Currently, 100% of inpatient cases must leave the service area for inpatient acute care services. Much of the inpatient volume utilizing St. Mary’s will be either tertiary in nature or have a length of stay in excess of 4.0 days and is not appropriate for a critical access hospital setting.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>2005</th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montrose</td>
<td>48.7%</td>
<td>54.4%</td>
<td>48.3%</td>
</tr>
<tr>
<td>St. Mary’s</td>
<td>31.3%</td>
<td>25.8%</td>
<td>30.6%</td>
</tr>
<tr>
<td>Mercy Medical Ctr</td>
<td>5.0%</td>
<td>4.2%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Aspen Valley</td>
<td>4.3%</td>
<td>2.7%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Other</td>
<td>10.7%</td>
<td>12.9%</td>
<td>16.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Source: Solucient.

**Service Area Population Segments**
Stroudwater Associates conducted numerous analyses to quantify the impact of non-resident population segments on the utilization of local healthcare services. The following table describes these population segments and the analyses performed to quantify each segment’s impact on health service demand.
Telluride Service Area Population Segments

<table>
<thead>
<tr>
<th>Population Segment</th>
<th>Quantity</th>
<th>Utilization Characteristics</th>
<th>Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year-round Permanent Residents</td>
<td>• 12,600 Total • 7,200 in PSA • 5,400 in SSA</td>
<td>• Urgent care • Emergent care • Specialty services • Preventive Care • Primary care • Potential for elective procedures • Physical therapy / rehab services</td>
<td>• FP/IM/Pediatrics • OB/Gyn • ED • Orthopedics • Podiatry • Urology • GI / Gen. Surgery • Dermatology • Anesthesia</td>
</tr>
<tr>
<td>Seasonal Residents &gt;4 months; &lt;12 months annually</td>
<td>TBD</td>
<td>• Urgent care • Emergent care • Limited primary care • Limited potential for elective procedures</td>
<td>• FP/IM • OB/Gyn • ED • Orthopedics • Podiatry • Urology • GI • Dermatology • Anesthesia</td>
</tr>
<tr>
<td>Undocumented Workers</td>
<td>1,000 in San Miguel County</td>
<td>• Primary Care • Urgent Care • Emergent Care</td>
<td>• FP/IM • ED • OB/Gyn</td>
</tr>
<tr>
<td>Commuters</td>
<td>4,000 vehicles daily</td>
<td>• Urgent care • Emergent care</td>
<td>• FP/IM • ED</td>
</tr>
<tr>
<td>Vacationers &lt;1 month annually</td>
<td>5,500 area hotel rooms</td>
<td>• Urgent care • Emergent care</td>
<td>• ED • Orthopedics</td>
</tr>
<tr>
<td>Medical Tourists</td>
<td>TBD</td>
<td>• Potential for Elective Procedures</td>
<td>• Plastics • Dermatology • Orthopedics • Anesthesia</td>
</tr>
</tbody>
</table>

Source: Health Demographics, local estimates, CDOT, Convention and Visitors Bureau.

To quantify the magnitude of seasonal population spikes, Stroudwater Associates analyzed local sales tax revenue figures by month. The variability in local sales tax revenue generation by month for Telluride and Mountain Village is highly correlated to the monthly patient volume variability experienced by TMC’s EC with an $R^2$ in excess of 90 percent. For Telluride, the seasonal variability in sales tax generated by month has increased considerably since 1987 and 1990 as the quantity of revenue generated has increased year to year.
Variability in Telluride’s monthly sales tax revenue receipts is lower than monthly patient volume variability at TMC’s EC. Telluride’s maximum to minimum monthly sales tax revenue multiple (maximum revenues / minimum revenue) is 3.4 and the average to minimum monthly sales tax revenue multiple (average revenues / minimum revenues) is 2.2. This contrasts with the comparable variability metrics in the EC of 4.99 and 2.64, respectively.
A comparable analysis of Mountain Village’s monthly sales tax receipts offers similar findings.

Mountain Village’s monthly sales tax revenues were flat from 2002 to 2004. For 2005 YTD, the average monthly sales tax receipts have experienced an increase due to more activity during the peak months of the year, as the following chart illustrates.
As the chart below indicates, Mountain Village experiences an extremely high maximum monthly revenue to minimum revenue multiple. This is the result of the extreme range between the peak sales tax revenue in March relative to the low revenue months of April-May and October-November. This pronounced variability is the result of the resort mountain village effect consistent with the changeover in activities immediately pre- and post-ski season.

Source: Town of Mountain Village.

Stroudwater Associates also analyzed monthly deplanements at the Telluride Regional Airport. The monthly and seasonal variability in deplanements also exhibits a pattern that is consistent with patient volume activity in TMC’s EC and local sales tax revenue receipts by month.
Monthly Deplanements at Telluride Regional Airport

Telluride Regional Airport Monthly Deplanements by Year

Monthly Deplanement Variability by Year

Source: Telluride Regional Airport.
The map fragment above depicts Colorado Department of Transportation annual average daily traffic counts for key routes within and adjacent to TMC’s service area. The above traffic counts indicate an average annual daily traffic (AADT) count of 8,000 on Route 145 adjacent the turnoff to Telluride. Total reflects 5,600 vehicles coming and going toward Norwood and Ridgway and 2,400 vehicles coming and going toward Ophir and Rico.

Combined, the non-permanent resident population segments create significant demand for emergent and urgent care services beyond the requirements generated by the permanent population in TMC’s service area. The best current estimate of the multiplier effect of non-resident populations on the demand for emergent care (EC) services is 2.5x base levels required by permanent residents and for the community clinic (CC) is 1.3x base levels. A critical opportunity for TMC to consider is the relative magnitude of emergent and urgent volume that currently leaves the area due to perceived or actual limits to TMC’s clinical capabilities. For example, several orthopedists have indicated that additional sports medicine cases could be retained locally and the quality and continuity of care for such cases improved with the addition of MRI capability at TMC.
Another opportunity concerns demand for elective procedures. The consensus opinion is that most elective healthcare services will be performed near the permanent home of seasonal residents, vacationers and commuters. As a result, the multiplier effect of the non-permanent populations on demand for elective services at TMC is presumed to be minimal. A multiplier of 1.0x base levels required by permanent residents is employed on elective healthcare services as a result. However, Telluride is an attractive destination for “medical tourists” who might prefer to have cosmetic surgical procedures performed away from home in a beautiful locale by a nationally renowned surgeon. This opportunity will warrant additional scrutiny closer as a new facility is being designed and programmed.

As a result of these analyses, Stroudwater Associates believes that demand for healthcare services and professionals within TMC’s service area should be adjusted to reflect the specific multiplier effect for seasonal, vacationing and commuting populations specific to each category of healthcare service – emergent (2.5x), primary care (1.3x) and elective (1.0x). Accordingly, Stroudwater’s analyses of future demand for healthcare services and healthcare providers within TMC’s service area utilize the above multipliers. Projections for specific new potential services also employ a range of market share estimates to provide TMC with a range of possible outcomes for these initiatives.

Estimating market size for the TMC service area requires applying the multiples calculated above to estimates and projections of inpatient and outpatient services.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TMC Service Area Population</td>
<td>6,036</td>
<td>6,785</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatients</td>
<td>249</td>
<td>291</td>
<td>286</td>
<td>335</td>
</tr>
<tr>
<td>Ambulatory O/P Procedures</td>
<td>20,153</td>
<td>21,603</td>
<td>26,199</td>
<td>28,084</td>
</tr>
<tr>
<td>Dx Radiology O/P Procedures</td>
<td>1,199</td>
<td>1,291</td>
<td>2,998</td>
<td>3,228</td>
</tr>
<tr>
<td>Lab O/P Procedures</td>
<td>6,895</td>
<td>7,414</td>
<td>8,964</td>
<td>9,638</td>
</tr>
<tr>
<td>ED / UC Visits</td>
<td>1,560</td>
<td>1,815</td>
<td>3,900</td>
<td>4,538</td>
</tr>
<tr>
<td>Subtotal</td>
<td>29,807</td>
<td>32,123</td>
<td>42,060</td>
<td>45,487</td>
</tr>
</tbody>
</table>

Source: Solucient.
The above estimates and projections suggest that the demand for inpatient services in TMC’s service area will grow by 16.8% from 2005 to 2010. For the same time period, the increase in outpatient services is projected to be 8.1%.

A similar approach for estimating the impact of non-resident demand can be applied to the need for physicians by specialty. The increased demand for healthcare services resulting from non-resident populations within TMC’s service area will impact the estimated need for physicians by specialty. The following table provides an overview of the projected need for physicians for key specialties including primary care, specialties that support the provision of surgical, diagnostic and emergency services as well as key surgical and medical specialties.
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Demand for Physician FTEs</th>
<th>2010 Local FTE Demand</th>
<th>Non-Resident Utilization</th>
<th>2010 Total FTE Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005</td>
<td>2010</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>FP/GP</td>
<td>2.4</td>
<td>2.7</td>
<td>0.82</td>
<td>1.10</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>1.5</td>
<td>1.7</td>
<td>0.50</td>
<td>0.66</td>
</tr>
<tr>
<td>OB/Gyn</td>
<td>0.7</td>
<td>0.8</td>
<td>0.24</td>
<td>0.32</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1.0</td>
<td>1.1</td>
<td>0.32</td>
<td>0.43</td>
</tr>
<tr>
<td>Primary Care</td>
<td>5.6</td>
<td>6.3</td>
<td>1.88</td>
<td>2.51</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>-</td>
<td>-</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>-</td>
<td>-</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Radiology</td>
<td>-</td>
<td>-</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>0.4</td>
<td>0.5</td>
<td>0.14</td>
<td>0.18</td>
</tr>
<tr>
<td>EC Related Specialties</td>
<td>0.4</td>
<td>0.5</td>
<td>0.14</td>
<td>0.18</td>
</tr>
<tr>
<td>Cardiology</td>
<td>0.3</td>
<td>0.3</td>
<td>0.09</td>
<td>0.12</td>
</tr>
<tr>
<td>Dermatology</td>
<td>0.2</td>
<td>0.2</td>
<td>0.06</td>
<td>0.08</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>0.2</td>
<td>0.2</td>
<td>0.06</td>
<td>0.08</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>0.6</td>
<td>0.7</td>
<td>0.21</td>
<td>0.28</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>1.2</td>
<td>1.4</td>
<td>0.42</td>
<td>0.56</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>0.2</td>
<td>0.2</td>
<td>0.06</td>
<td>0.07</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>ENT</td>
<td>0.2</td>
<td>0.2</td>
<td>0.07</td>
<td>0.09</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0.1</td>
<td>0.1</td>
<td>0.02</td>
<td>0.03</td>
</tr>
<tr>
<td>General Surgery</td>
<td>0.7</td>
<td>0.8</td>
<td>0.24</td>
<td>0.32</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0.1</td>
<td>0.1</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>Urology</td>
<td>0.1</td>
<td>0.2</td>
<td>0.07</td>
<td>0.09</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>1.4</td>
<td>1.6</td>
<td>0.47</td>
<td>0.63</td>
</tr>
<tr>
<td>Other Specialties</td>
<td>1.0</td>
<td>1.1</td>
<td>0.32</td>
<td>0.42</td>
</tr>
<tr>
<td>Total</td>
<td>9.57</td>
<td>10.8</td>
<td>3.23</td>
<td>4.30</td>
</tr>
</tbody>
</table>

Source: Solucient, GMENAC, Hicks & Glen, and Group Health.
*Low scenario assumes low mkt share & 235 surgical cases per FTE annually. 50% of OB/Gyn FTEs assumed to be surgical.
**High scenario assumes high mkt share & 275 surgical cases per FTE annually. 50% of OB/Gyn FTEs assumed to be surgical.
Orthopedics is projected to generate 400 cases annually per FTE - per Stroudwater’s experience.

As previously noted, specialties directly involved in the provision of emergency care and sports medicine services as provided by the EC are estimated to experience a non-permanent resident demand multiplier of 2.5x. Those specialties providing primary care services similar to those offered by the CC are estimated to experience a non-permanent resident demand multiplier of 1.3x. Specialties that are elective in nature are not expected to be impacted by the influx of seasonal, vacationing, and commuter traffic.
Payer Mix

Gross payer mix for TMC’s EC and CC is detailed below. There is a significant difference in the payer mix between these two business units, with the EC experiencing a higher proportion of self-pay and bad debt.

<table>
<thead>
<tr>
<th>2005 CC Gross Payer Mix</th>
<th>2005 EC Payer Gross Payer Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross</td>
<td>Blue Cross</td>
</tr>
<tr>
<td>19.8%</td>
<td>28.9%</td>
</tr>
<tr>
<td>Rocky Mtn HMO</td>
<td>Rocky Mtn HMO</td>
</tr>
<tr>
<td>16.7%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Mountain Medical</td>
<td>Mountain Medical</td>
</tr>
<tr>
<td>8.7%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Other Commercial</td>
<td>Other Commercial</td>
</tr>
<tr>
<td>12.7%</td>
<td>15.1%</td>
</tr>
<tr>
<td>Self Pay - Collected</td>
<td>Self Pay - Collected</td>
</tr>
<tr>
<td>18.9%</td>
<td>23.1%</td>
</tr>
<tr>
<td>Self Pay - Bad Debt</td>
<td>Self Pay - Bad Debt</td>
</tr>
<tr>
<td>10.1%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Medicaid</td>
</tr>
<tr>
<td>3.9%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Medicare</td>
<td>Medicare</td>
</tr>
<tr>
<td>5.8%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Work Comp</td>
<td>Work Comp</td>
</tr>
<tr>
<td>3.4%</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

Source: TMC.

TMC has elected not to renew its Blue Cross contract. In 2006 Blue Cross patients will be responsible for paying their TMC bills directly and will subsequently be reimbursed by Blue Cross. TMC assists its Blue Cross patients with their paperwork. Payer mix for FY 2006 YTD is provided below.
<table>
<thead>
<tr>
<th>2006 CC Gross Payer Mix</th>
<th>2006 EC Gross Payer Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross</td>
<td>Blue Cross</td>
</tr>
<tr>
<td>22.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Contracted</td>
<td>Contracted</td>
</tr>
<tr>
<td>40.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Non-Contracted</td>
<td>Non-Contracted</td>
</tr>
<tr>
<td>14.0%</td>
<td>32.0%</td>
</tr>
<tr>
<td>Medicare</td>
<td>Medicare</td>
</tr>
<tr>
<td>5.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Medicaid</td>
</tr>
<tr>
<td>3.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>Self-Pay</td>
</tr>
<tr>
<td>16.0%</td>
<td>19.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
TMC Operational and Financial Performance (update)

An assessment of key operating and financial ratios at TMC sheds light on the recent performance of its two business units. From 2001 through 2005, EC visits have grown nearly 89% while CC visits have been flat, having fallen 2.1% over the same time period.

Comparing actual 2004 performance with budgeted 2006 performance indicates that TMC is projecting a 20.3% increase in revenue between 2004 and 2006 accompanied by a 0.1% increase in expense levels over the same time period. The change is most pronounced in the Community Clinic, where revenues are projected to increase more than 50% from 2004 to 2006 while expenses are expected to decline by 9.9% over the same time period.

The growth in CC revenues will be achieved from declining visits, projected to fall by 222 visits or 2.1% from 2004 to 2006. The CC will need to increase net revenue per visit by 66.5% from $79 to $132 between 2004 and 2006 to achieve these results.

For the EC, operating revenues are projected to increase almost 9% on visit growth of 18.3% from 2004 to 2006. This suggests a reduction in net operating revenue per visit of 8% over the same time period. EC staffing costs per visit are projected to decline by 30% from 2004 to 2006.

The CC is forecasted to offset a slight decline in visit volume by significantly increasing payment per visit. The EC will utilize growing volumes and a more efficient staffing pattern to offset falling revenue per visit over the same time period.

The net effect of enhanced revenue yield per visit in the CC, growing visit volumes in the EC, and more efficient staffing patterns overall is projected profitability for the CC on a stand alone basis in 2006 coupled with a continued positive total margin for the EC after the benefit of the mill levy is included.

Revenue yield and staffing efficiency are the two variables for which TMC management has the greatest short-term control. TMC staffing expense as a percent of total expenses is projected to fall increase slightly in the EC while
falling by more than five percentage points (from 84.8% to 79.2%) from 2004 to 2006. Given the large share of total TMC expenses represented by salaries, wages and benefits, effectively managing this expense category is essential to TMC’s financial solvency.

<table>
<thead>
<tr>
<th>Key Operating Trends at TMC</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>'01 to '05 Change</th>
<th>'04 to '06 Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC Visits</td>
<td>1,849</td>
<td>1,909</td>
<td>2,620</td>
<td>3,052</td>
<td>3,492</td>
<td>3,610</td>
<td>88.9%</td>
<td>18.3%</td>
</tr>
<tr>
<td>CC Visits</td>
<td>10,263</td>
<td>9,973</td>
<td>9,618</td>
<td>10,546</td>
<td>10,913</td>
<td>10,324</td>
<td>6.3%</td>
<td>-2.1%</td>
</tr>
<tr>
<td>EC Total Margin</td>
<td>7.4%</td>
<td>3.2%</td>
<td>10.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CC Total Margin</td>
<td>-52.4%</td>
<td>-22.6%</td>
<td>8.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TMC Total Margin</td>
<td>-5.4%</td>
<td>0.5%</td>
<td>12.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EC Total Revenues</td>
<td>$2,503,685</td>
<td>$2,399,833</td>
<td>$2,736,296</td>
<td></td>
<td></td>
<td></td>
<td>9.3%</td>
<td></td>
</tr>
<tr>
<td>CC Total Revenues</td>
<td>$917,800</td>
<td>$1,032,792</td>
<td>$1,380,746</td>
<td></td>
<td></td>
<td></td>
<td>50.4%</td>
<td></td>
</tr>
<tr>
<td>TMC Total Revenues</td>
<td>$3,421,485</td>
<td>$3,432,625</td>
<td>$4,117,042</td>
<td></td>
<td></td>
<td></td>
<td>20.3%</td>
<td></td>
</tr>
<tr>
<td>EC Expenses</td>
<td>$2,317,879</td>
<td>$2,322,932</td>
<td>$2,460,966</td>
<td></td>
<td></td>
<td></td>
<td>6.2%</td>
<td></td>
</tr>
<tr>
<td>CC Expenses</td>
<td>$1,398,540</td>
<td>$1,266,110</td>
<td>$1,260,606</td>
<td></td>
<td></td>
<td></td>
<td>-9.9%</td>
<td></td>
</tr>
<tr>
<td>TMC Expenses</td>
<td>$3,716,419</td>
<td>$3,589,042</td>
<td>$3,721,562</td>
<td></td>
<td></td>
<td></td>
<td>0.1%</td>
<td></td>
</tr>
<tr>
<td>EC % Staffing Exp / Total Exp</td>
<td>85.3%</td>
<td>84.3%</td>
<td>85.6%</td>
<td></td>
<td></td>
<td></td>
<td>0.4%</td>
<td></td>
</tr>
<tr>
<td>CC % Staffing Exp / Total Exp</td>
<td>89.2%</td>
<td>84.8%</td>
<td>79.2%</td>
<td></td>
<td></td>
<td></td>
<td>-11.2%</td>
<td></td>
</tr>
<tr>
<td>CC Staff Expense</td>
<td>$1,977,074</td>
<td>$1,966,230</td>
<td>$2,105,623</td>
<td></td>
<td></td>
<td></td>
<td>6.5%</td>
<td></td>
</tr>
<tr>
<td>Staff Expense Per Visit</td>
<td>$167.47</td>
<td>$179.53</td>
<td>$203.96</td>
<td></td>
<td></td>
<td></td>
<td>8.8%</td>
<td></td>
</tr>
<tr>
<td>CC Op Revenue</td>
<td>$636,713</td>
<td>$1,027,193</td>
<td>$1,363,682</td>
<td></td>
<td></td>
<td></td>
<td>63.0%</td>
<td></td>
</tr>
<tr>
<td>CC Op Revenue Per Visit</td>
<td>$79.34</td>
<td>$94.13</td>
<td>$132.09</td>
<td></td>
<td></td>
<td></td>
<td>66.5%</td>
<td></td>
</tr>
<tr>
<td>EC Staff Expense</td>
<td>$1,247,902</td>
<td>$1,073,812</td>
<td>$998,753</td>
<td></td>
<td></td>
<td></td>
<td>-20.0%</td>
<td></td>
</tr>
<tr>
<td>Staff Expense Per Visit</td>
<td>$406.68</td>
<td>$307.51</td>
<td>$276.66</td>
<td></td>
<td></td>
<td></td>
<td>-32.3%</td>
<td></td>
</tr>
<tr>
<td>EC Op Revenue</td>
<td>$1,130,115</td>
<td>$1,084,682</td>
<td>$1,228,777</td>
<td></td>
<td></td>
<td></td>
<td>8.7%</td>
<td></td>
</tr>
<tr>
<td>EC Op Revenue Per Visit</td>
<td>$370.29</td>
<td>$310.62</td>
<td>$340.38</td>
<td></td>
<td></td>
<td></td>
<td>-8.1%</td>
<td></td>
</tr>
</tbody>
</table>
Discussion Regarding Options for Supporting TMC’s EC and CC

TMC is currently designated a Rural Health Center by the State of Colorado and CMS. This designation provides for enhanced reimbursement for Medicare and Medicaid patient visits for TMC. However, TMC is currently not billing for Medicare and Medicaid visits as a Rural Health Center (RHC) and is therefore not realizing the financial benefits of its RHC designation. Because TMC has a very low share of Medicare (4.2%) and Medicaid (1.8%) visits, the financial impact of the RHC designation is limited.

Stroudwater Associates’ preliminary analysis indicates that billing as an RHC would provide an estimated $17,000 additional reimbursement annually at current patient visit levels for Medicare and Medicaid. Should TMC experience additional Medicaid or Medicare patient visits, the financial benefit would increase. The table below details Stroudwater Associates’ preliminary estimate of the impact from billing as an RHC.

| Estimated Financial Impact of Operationalizing TMC’s Rural Health Center Designation |
|---------------------------------|----------------|----------------|----------------|----------------|----------------|
| UC Patient Visits               | 3,492       | 3,610        | 3,732          | 3,858          | 3,988          |
| CC Patient Visits               | 10,913      | 10,324       | 10,324         | 10,324         | 10,324         |
| Subtotal TMC Patient Visits     | 14,405      | 13,934       | 14,056         | 14,182         | 14,312         |
| Growth from Prior Year          | 5.9%        | -3.3%        | 0.9%           | 0.9%           | 0.9%           |
| % of Patient Visits Paid by Medicaid | 4.2%      | 4.2%         | 4.2%           | 4.2%           | 4.2%           |
| % of Patient Visits Paid by Medicare | 1.8%      | 1.8%         | 1.8%           | 1.8%           | 1.8%           |
| Estimated Medicaid Visits       | 605         | 585          | 590            | 596            | 601            |
| Estimated Medicare Visits       | 259         | 251          | 253            | 255            | 258            |
| Est. Visits Eligible for Enhanced Payment | 864     | 836          | 843            | 851            | 859            |
| Estimate of RHC Status Benefit Per Visit | $ 20 | $ 20 | $ 20 | $ 20 | $ 20 |
| Estimate of Provider Based RHC Status Per Visit | $ 40 | $ 40 | $ 40 | $ 40 | $ 40 |
| Annual Gain from Billing as an RHC | $ 17,286 | $ 16,721 | $ 16,867 | $ 17,019 | $ 17,175 |
| Annual Gain from Becoming Provider-Based RHC | $ 34,572 | $ 33,442 | $ 33,734 | $ 34,037 | $ 34,350 |
Stroudwater Associates’ preliminary assessment also looked at the potential of TMC becoming a provider-based RHC. The advantage of this designation is that the enhanced cost-based payments for an RHC are no longer capped as a provider-based RHC. A more thorough analysis will be necessary to determine the precise impact of the provider-based designation, but Stroudwater’s experience with RHCs and provider-based RHCs indicates that an additional $20 per Medicare and Medicaid visit is a reasonable estimate of the benefit attained through provider-based status. A greater benefit is possible, depending upon TMC’s cost-structure. Stroudwater’s preliminary assessment of the impact from TMC becoming a provider-based Rural Health Clinic is $34,000 annually.

Fully implementing TMC’s RHC status will necessitate TMC to meet some additional requirements. The table below summarizes some of the key operational and managerial requirements associated with RHCs and provider-based RHCs.

<table>
<thead>
<tr>
<th>Rural Health Clinic</th>
<th>Provider-Based Rural Health Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Any type of corporate status is allowable</td>
<td>• Same as Rural Health Clinic, but also requires the following:</td>
</tr>
<tr>
<td>• Location is current HPSA, HPSP, or MUA</td>
<td>• Main provider and department must be operated under same license</td>
</tr>
<tr>
<td>• Midlevel practitioners provide service at least 50% of time clinic is open</td>
<td>• Full integration of clinical services with main provider</td>
</tr>
<tr>
<td>• Referral arrangements for hospital and specialty care</td>
<td>• Full integration of financial operations with main provider</td>
</tr>
<tr>
<td>• Policy and Procedure Manual</td>
<td>• Public and payer awareness that RHC is part of main provider</td>
</tr>
<tr>
<td>• On-site survey by State Licensure Agency</td>
<td>• RHC is operated under ownership and control of main provider</td>
</tr>
<tr>
<td></td>
<td>• Location within a straight-line 35 mile radius of main provider, or</td>
</tr>
<tr>
<td></td>
<td>• Exemption if main provider is</td>
</tr>
</tbody>
</table>
The major stumbling block facing TMC in attaining the benefits of provider-based RHC status is that there are no entities that meet the 35 mile rule and the only entity that can meet the 75/75 exemption is Montrose. This option is not palatable to TMC given the recent experience with Montrose as the manager of TMC. However, a solution does exist for TMC.

Because TMC is more than 35 miles from the nearest hospital, it is eligible to become a Critical Access Hospital (CAH). The main clinical and operational requirement of designation is to provide 24/7 emergency services with physicians on call and available on-site within 30-minutes. The inpatient component of a CAH can be skilled nursing beds and/or acute beds – not to exceed 25 total beds. There is no minimum bed size for a CAH. TMC’s Emergency Clinic operations as currently configured and a minimum complement of skilled nursing and/or acute care beds would enable TMC to become a CAH. The inpatient beds can be used interchangeably between acute care, observation, and skilled nursing purposes as long as the facility is appropriately licensed to provide acute and skilled nursing care. Stroudwater believes that attaining CAH status for TMC in conjunction with the affiliated primary care practice becoming a provider-based Rural Health Clinic could provide a necessary cornerstone for TMC to improve its financial future as well as to better meet the unique needs of Telluride and its environs.

Importantly, a Critical Access Hospital is required to have a referral partner to facilitate seamless referrals of cases that are inappropriate for a Critical Access Hospital given their expected length of stay, acuity and need for specialty care. St. Mary’s Hospital in Grand Junction might be an ideal referral partner given its resources, number of affiliated specialists, and track record in working with smaller hospitals on the western slope of the Rocky Mountains.

Stroudwater Associates is not suggesting that TMC should become a Critical Access Hospital to secure an additional $34,000 in revenue annually. The enhanced reimbursement available to a CAH and affiliated RHC is only one part of the picture. As important for TMC’s future is the opportunity to expand the array of services and clinical capabilities available locally.

This opportunity has two clear benefits. First, TMC or its successor would retain a greater share of healthcare dollars spent by area residents – permanent, seasonal, transient – via the enhanced patient volumes associated with expanded clinical capabilities. Second, payers in Colorado routinely pay a
percentage of hospital charges which is a potentially more advantageous payment methodology for TMC. The attached CAH financial analysis illustrates the advantages derived from both of these factors.

Stroudwater Associates did complete a financial feasibility analysis regarding the potential for TMC to convert to a Critical Access Hospital. This was done using a variety of scenarios, including: a) maintaining the existing CC/EC service program and only adding hospital beds to accommodate occasional medical admissions; b) adding an ambulatory surgery capacity to the above; c) adding MRI services as well; and d) adding outpatient rehabilitation services as well. The results of each of these analyses are summarized in the following table, and the complete analysis of each iteration is included in the appendix.
<table>
<thead>
<tr>
<th>OPERATING REVENUE:</th>
<th>Hospital</th>
<th>Hospital</th>
<th>Hospital</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2008 TMC Budget</td>
<td>No ASC, No MRI, No PT</td>
<td>ASC, No MRI, No PT</td>
<td>ASC, MRI, No PT</td>
</tr>
<tr>
<td>Inpatient Revenue:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Acute</td>
<td>449,000</td>
<td>392,000</td>
<td>391,000</td>
<td>391,000</td>
</tr>
<tr>
<td>Swing Bed (SNF and NF)</td>
<td>69,000</td>
<td>59,000</td>
<td>56,000</td>
<td>104,000</td>
</tr>
<tr>
<td>Total Inpatient Revenue</td>
<td>518,000</td>
<td>451,000</td>
<td>447,000</td>
<td>495,000</td>
</tr>
<tr>
<td>Outpatient Revenue:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Room</td>
<td>363,000</td>
<td>354,000</td>
<td>349,000</td>
<td></td>
</tr>
<tr>
<td>Radiology - Diagnostic</td>
<td>721,000</td>
<td>700,000</td>
<td>697,000</td>
<td>696,000</td>
</tr>
<tr>
<td>CT Scan</td>
<td>234,000</td>
<td>225,000</td>
<td>224,000</td>
<td>224,000</td>
</tr>
<tr>
<td>MRI</td>
<td></td>
<td></td>
<td>594,000</td>
<td>593,000</td>
</tr>
<tr>
<td>Laboratory</td>
<td>322,000</td>
<td>299,000</td>
<td>297,000</td>
<td>296,000</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>52,000</td>
<td>51,000</td>
<td>51,000</td>
<td>51,000</td>
</tr>
<tr>
<td>Medical Supplies Charged to Patients</td>
<td>74,000</td>
<td>72,000</td>
<td>72,000</td>
<td>72,000</td>
</tr>
<tr>
<td>Drugs Charged to Patients</td>
<td>83,000</td>
<td>79,000</td>
<td>79,000</td>
<td>79,000</td>
</tr>
<tr>
<td>Emergency (see note below)</td>
<td>1,229,000</td>
<td>920,000</td>
<td>912,000</td>
<td>909,000</td>
</tr>
<tr>
<td>Outpatient Observation</td>
<td>54,000</td>
<td>54,000</td>
<td>54,000</td>
<td>54,000</td>
</tr>
<tr>
<td>Rural Health Clinic</td>
<td>1,364,000</td>
<td>748,000</td>
<td>728,000</td>
<td>722,000</td>
</tr>
<tr>
<td>Total Outpatient Revenue</td>
<td>2,593,000</td>
<td>3,208,000</td>
<td>3,483,000</td>
<td>4,033,000</td>
</tr>
<tr>
<td>Net Patient Revenue</td>
<td>2,593,000</td>
<td>3,726,000</td>
<td>3,934,000</td>
<td>4,500,000</td>
</tr>
<tr>
<td>Mill Levy Income</td>
<td>1,655,000</td>
<td>1,655,000</td>
<td>1,655,000</td>
<td>1,655,000</td>
</tr>
<tr>
<td>Other Operating Revenue</td>
<td>20,000</td>
<td>20,000</td>
<td>20,000</td>
<td>20,000</td>
</tr>
<tr>
<td>Total Operating Revenue</td>
<td>4,268,000</td>
<td>5,401,000</td>
<td>5,609,000</td>
<td>6,175,000</td>
</tr>
<tr>
<td>OPERATING EXPENSES:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>2,212,000</td>
<td>2,745,000</td>
<td>2,825,000</td>
<td>2,865,000</td>
</tr>
<tr>
<td>Benefits, Supplies, &amp; Other</td>
<td>1,212,000</td>
<td>1,748,000</td>
<td>1,808,000</td>
<td>2,003,000</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>264,000</td>
<td>1,000,000</td>
<td>1,000,000</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Interest</td>
<td>89,000</td>
<td>1,462,500</td>
<td>1,463,000</td>
<td>1,463,000</td>
</tr>
<tr>
<td>Bad debt expense (see note below)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Operating Expenses</td>
<td>3,777,000</td>
<td>6,955,500</td>
<td>7,096,000</td>
<td>7,331,000</td>
</tr>
<tr>
<td>GAIN (LOSS) FROM OPERATIONS</td>
<td>491,000</td>
<td>(1,554,500)</td>
<td>(1,487,000)</td>
<td>(1,136,000)</td>
</tr>
<tr>
<td>NONOPERATING REVENUE, NET</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants</td>
<td>34,000</td>
<td>34,000</td>
<td>34,000</td>
<td>34,000</td>
</tr>
<tr>
<td>Other Non-Operating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mill for Annual Debt Service (6.5%, 22.5M, 30y)</td>
<td>1,723,000</td>
<td>1,723,000</td>
<td>1,723,000</td>
<td>1,723,000</td>
</tr>
<tr>
<td>Total Nonoperating Gains, net</td>
<td>34,000</td>
<td>1,757,000</td>
<td>1,757,000</td>
<td>1,757,000</td>
</tr>
<tr>
<td>CHANGE IN NET ASSETS</td>
<td>525,000</td>
<td>202,500</td>
<td>270,000</td>
<td>601,000</td>
</tr>
</tbody>
</table>

Note: '06 revenue shown as net revenue per budget, '08 shown by department
Note: Revenues are shown on net basis, which includes adjustments to gross revenue for write off/bad debts

Since the core assumptions used are key to the results attained, following is a brief summary of the assumptions that were applied:
Inpatient Assumptions

- **Acute Beds**
  - 133 cases total
  - 15% of overall market share (2009 projected)

- **Swing Beds**
  - Assumed 25% of total Medicare acute
  - Additional opportunity per transfer rule not considered

- **Observation Beds**
  - 23-hour stays, assumed 150 days
  - Staffed in inpatient acute beds with low incremental costs

- **Average Daily Census**
  - 3.5 Average length of stay generates 466 days, or 1.3 patients per day ADC

- **Payer Mix**
  - 30% Medicare, 20% Medicaid/Self Pay, 50% Commercial

- **Contracting**
  - Medicare – 101% of costs
  - Medicaid/Self - $800 per day (net)
  - Commercial - $1,600 per day (net)

Outpatient Assumptions

- **Rate Setting**
  - Ancillary markup on fully allocated costs = 3.0
    - Colorado average is 3.22
    - Average charge per X-Ray = $390, net = $313
  - Outpatient = higher fixed cost services, therefore lower pricing relative to costs
    - OR, ER, RHC = charges at 85% of costs
    - Example: Total RHC charges of $1 million on 11,000 visits ($92 per visit), net = $74
  - Rehab services were included in one scenario and may or may not be jointly developed with existing PT like MRI/ASC model

- **Payer Mix**
  - RHC and ER assumed at historical rates (5% Medicare/58% Commercial/37% all other)
  - Ancillary services assumed at 10% Medicare/58% commercial/32% all other
    - Except OR and Lab assumed to be 15% due to higher use rates by Medicare

- **Self-Pay/Collections**
  - Assumed at 25% of charges
    - ER net of $57 per visit
    - RHC net of $23 per visit

Operating Cost Assumptions

- **Salary/Benefits**
  - Assumed adding $630,000 (06 budget = $2.3M after grossing up to 2008 by 3% annually)
- OR = $190K salaries
- Acute = $125K (plus $100K allocation from ER)
- MRI = $40K
- ER = $50K (net of shared with acute)
- Overhead = $225K (MR, admin, pharmacy, housekeeping, maintenance)
  - Maintain 25% O/H ratio

**Benefits/other costs**
- Assumed adding $372,000 (06 budget = $1.3M after grossing up to 2008 by 5% annually)
  - Benefits increased by $160K based on 25% of total additional staffing
  - Other costs related to supplies/cost of goods sold

**Facility Costs**
- $15,000,000 depreciated over 25 years ($600K annually)
- $13.5M financed at 6.5% ($878K first year)
  - Medicare capital paid at 101% of costs

**Other Considerations**
- Working Capital Needs
  - Does not project for need in working capital
- Conversion Sequence Assumptions
  - Without hospital license, TMC cannot open up as a CAH on day one
  - Must first open as general acute hospital, with approx. 6 month lag in getting license, then additional 3-4 month lag in conversion to CAH
Discussion of MRI Service Feasibility

The overall market for MRI services within the TMC service area is assumed to be much larger than national use rates would indicate. Applying national use rates to TMC’s catchment area yields an estimated market of around 430 MRIs annually for the entire service area. However, this market size estimate is based on only the year-round, permanent resident population and national use rates.

The same Solucient forecasting tool estimates that annual CT utilization within the TMC service area is 646 cases in 2005. TMC’s budget for FY 2006 assumes 446 CT procedures will be performed on-site translating into a 70% market share. However, it is likely that TMC’s market share is actually lower as non-permanent residents will increase utilization of CT and MRI services. It is clear that for diagnostic services related to sports injuries associated with peak visitor activity, utilization of MRI services will outstrip projections.

For purposes of this assessment we have assumed that TMC will retain the equivalent of 70% of the 430 projected MRI cases in 2010. This assumption treats MRI retention of cases similarly to current experience with CT cases. Accordingly, we assume 300 MRI cases as the base case for TMC going forward.

Beyond service volumes, key drivers of financial feasibility include the ability of TMC to successfully negotiate more attractive payment terms for this service. Service volumes will be greatly affected by the degree to which local physicians will support the service. Nationally, the trend in MRI utilization along with other diagnostic modalities, has been increasing. With an underlying growing population, demand for MRI services in Telluride can be expected to increase in the coming years.
<table>
<thead>
<tr>
<th>Expense Line Item</th>
<th>Nature of Expense</th>
<th>Scenario One: All Costs Born by Svc</th>
<th>Scenario Two: MRI Unit Donated</th>
<th>Scenario Three: MRI and Facility Donated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment Cap Ex</td>
<td>Fixed Annual Expense</td>
<td>$176,000 $</td>
<td>$ - $</td>
<td>$ - $</td>
</tr>
<tr>
<td>Equipment Depreciation Fixed Annual Expense</td>
<td>$160,000 $</td>
<td>$160,000 $</td>
<td>$160,000 $</td>
<td></td>
</tr>
<tr>
<td>Service Fixed Annual Expense</td>
<td>$7,500 $</td>
<td>$7,500 $</td>
<td>$7,500 $</td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>Fixed Annual Expense</td>
<td>$40,000 $</td>
<td>$40,000 $</td>
<td>$40,000 $</td>
</tr>
<tr>
<td>Space Costs Fixed Annual Expense</td>
<td>$40,000 $</td>
<td>$40,000 $</td>
<td>$ - $</td>
<td></td>
</tr>
<tr>
<td>Utilities Fixed Annual Expense</td>
<td>$25,000 $</td>
<td>$25,000 $</td>
<td>$25,000 $</td>
<td></td>
</tr>
<tr>
<td>Overhead Fixed Annual Expense</td>
<td>$50,000 $</td>
<td>$50,000 $</td>
<td>$50,000 $</td>
<td></td>
</tr>
<tr>
<td>Film/Contrast Variable Cost Per Scan</td>
<td>$40 $</td>
<td>$40 $</td>
<td>$40 $</td>
<td></td>
</tr>
<tr>
<td>Supplies Variable Cost Per Scan</td>
<td>$10 $</td>
<td>$10 $</td>
<td>$10 $</td>
<td></td>
</tr>
<tr>
<td>Billing Variable Cost Per Scan</td>
<td>$30 $</td>
<td>$30 $</td>
<td>$30 $</td>
<td></td>
</tr>
<tr>
<td><strong>Total Fixed Annual Expenses</strong></td>
<td>$498,500 $</td>
<td>$322,500 $</td>
<td>$282,500 $</td>
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</tr>
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</table>

**Scenario One: Breakeven Analysis**

<table>
<thead>
<tr>
<th>Annual MRI Scans</th>
<th>Lost CT Volume**</th>
<th>$850 per Exam</th>
<th>$1,000 per Exam</th>
<th>$1,150 per Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>250</td>
<td>10</td>
<td>(309,100) $</td>
<td>(271,220) $</td>
<td>(233,340) $</td>
</tr>
<tr>
<td>300</td>
<td>12</td>
<td>(271,220) $</td>
<td>(226,220) $</td>
<td>(180,840) $</td>
</tr>
<tr>
<td>350</td>
<td>14</td>
<td>(234,100) $</td>
<td>(181,220) $</td>
<td>(128,340) $</td>
</tr>
<tr>
<td>400</td>
<td>16</td>
<td>(133,100) $</td>
<td>(95,220) $</td>
<td>(57,340) $</td>
</tr>
</tbody>
</table>

**Scenario Two: Breakeven Analysis with Donated MRI Unit**

<table>
<thead>
<tr>
<th>Annual MRI Scans</th>
<th>Lost CT Volume**</th>
<th>$850 per Exam</th>
<th>$1,000 per Exam</th>
<th>$1,150 per Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>250</td>
<td>10</td>
<td>(133,100) $</td>
<td>(95,220) $</td>
<td>(57,340) $</td>
</tr>
<tr>
<td>300</td>
<td>12</td>
<td>(95,220) $</td>
<td>(50,220) $</td>
<td>(4,840) $</td>
</tr>
<tr>
<td>350</td>
<td>14</td>
<td>(58,100) $</td>
<td>(5,220) $</td>
<td>47,660 $</td>
</tr>
<tr>
<td>400</td>
<td>16</td>
<td>(58,100) $</td>
<td>(5,220) $</td>
<td>100,540 $</td>
</tr>
</tbody>
</table>

**Scenario Three: Breakeven Analysis with Donated MRI Unit and Facility**

<table>
<thead>
<tr>
<th>Annual MRI Scans</th>
<th>Lost CT Volume**</th>
<th>$850 per Exam</th>
<th>$1,000 per Exam</th>
<th>$1,150 per Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>250</td>
<td>10</td>
<td>(83,100) $</td>
<td>(55,220) $</td>
<td>(17,340) $</td>
</tr>
<tr>
<td>300</td>
<td>12</td>
<td>(55,220) $</td>
<td>(10,220) $</td>
<td>35,160 $</td>
</tr>
<tr>
<td>350</td>
<td>14</td>
<td>(18,100) $</td>
<td>34,780 $</td>
<td>87,660 $</td>
</tr>
<tr>
<td>400</td>
<td>16</td>
<td>(18,100) $</td>
<td>34,780 $</td>
<td>140,540 $</td>
</tr>
</tbody>
</table>

**Notes:**

* Personnel cost assumes additional RT coverage required during peak periods with RTs being cross trained across modalities. Without cross training, personnel costs could be expected to double.

**MRI is assumed to cannibalize 4% of CT cases annually - this lost revenue has been incorporated into this analysis.

Revenue foregone per lost CT scan: $350

Joint-venturing an MRI service with interested specialists is likely to best ensure that TMC and the community’s investment in this new service will be successful. Specialists expressed significant interest in jointly owning an MRI service with TMC. To ensure that physicians utilize the MRI service, it is vital that ownership of the MRI service at TMC be as widespread as possible. TMC should not enter into a joint venture arrangement that would exclude key potential referrers for this service.

Should TMC pursue such a “syndication” model for this new MRI service, the MRI would not be eligible for cost-based reimbursement under RHC, provider-based RHC, or CAH status. However, the economics of MRI services are such that syndication of an MRI with referring physicians more than compensates for the foregone cost-based reimbursement. This decision is made easier for TMC given that Medicare and Medicaid patients comprise only 6% of TMC patient visit volume.
Stroudwater Associates tested the feasibility for MRI services by conducting a sensitivity analysis on several key assumptions: (i) annual MRI volume; (ii) average revenue per MRI, and; (iii) the impact of eliminating some of all capital costs via a community campaign. It was assumed that 4% of MRI volume would replace existing CT volume and that the additional staffing expense associated with the new MRI service would be offset via cross training.

A key consideration is the gains in reimbursement realized by becoming a CAH rather than a clinic. In Colorado, most payers pay a percent of hospital charges. This payment methodology can potentially be quite beneficial for providers when compared to clinic-based reimbursement methodologies. The Stroudwater sensitivity analysis depicts the MRI as a marginal proposition from a profitability standpoint. However, if the local medical community feels that such a diagnostic tool would benefit area residents and visitors who require imaging services, a more detailed feasibility study should be developed. At a minimum, plans for a future facility should include flexibility and possibly provisions for development of an MRI services at TMC.

It is important to note that the financial feasibility of an MRI service at TMC is greatly enhanced if the capital costs associated with such a service – equipment and facility costs – are assumed to be donated via a community capital campaign.
Discussion of Ambulatory Surgery / Outpatient Procedure Service Feasibility

Stroudwater has employed three methodologies for estimating the size of the market for ambulatory surgery services within TMC’s service area. The first, depicted below, looks at the demand for physicians in the surgical specialties and applies an estimate of surgical activity generated per physician FTE across these specialties. The specialties assumed to generate ambulatory surgical cases are: obstetrics/gynecology, orthopedics, gastroenterology, podiatry, ENT, neurosurgery, general surgery, plastic surgery and urology.

Stroudwater has generated an estimate of physician FTE demand by specialty. The only specialty not included in the analysis is podiatry. The 2009 physician demand in FTEs was then adjusted for market share – scenarios from 30% to 50% - and also for the estimated impact of seasonality upon demand for services.

Specialties directly involved in the provision of emergent care and sports medicine were assumed to be in demand 2.5x above the requirements of permanent residents of the service area. For this analysis, only emergency medicine, orthopedics, and radiology are estimated to experience demand 2.5x the level required by permanent residents. Cardiology and general surgery were assumed to experience a somewhat elevated demand for services in line with primary care specialties (internal medicine, family practice, pediatrics, obstetrics/gynecology). Because these specialties are not involved in caring for sports related injuries, they are assumed to experience elevated demand in line with the experience of TMC’s primary care practice or 1.3x the requirements of permanent residents of the service area. All other specialties are expected not to be impacted by the influx of non-permanent residents given the elective or scheduled nature of the services they provide. It is assumed that visitors schedule these procedures when they are at their permanent residence.

This methodology assumes ambulatory surgical volumes of between 299 and 545 cases annually for ambulatory surgery at TMC – given a market share range of 30% at the low end and 50% at the high end. This analysis yields an estimate of market size of 897 at the low end to 1,090 at the high end. Given the likelihood that most sports related injuries will be treated closer to visitors’ permanent homes, the lower end of the market share range seems more plausible. It is important to note that a rule of thumb suggests that 1,000 cases annually is sufficient need for one ambulatory surgical operating room.
A second methodology utilizes the proprietary demand forecasting models of Solucient. This model suggests that 2010 demand for ambulatory surgical procedures by permanent residents of the service area will be 1,590 cases. This permanent resident demand estimate for 2009 provides us with a low range estimate. Applying a multiplier of 1.3x to the permanent resident demand provides a high range estimate of 2,067 for total market ambulatory surgery procedures. Multiplying these estimates of total market size by our range estimates for TMC market share of 30% to 50% yields an estimated 2010 market potential for ambulatory surgeries at TMC of 620 to 1,033 cases annually.
A third methodology to estimate the size of the ambulatory surgery market within the TMC service area is to apply use rates to the service area population. This methodology produces a range estimate of total market size of 788 to 1,025 for outpatient surgeries in the TMC service area. Once market share range estimates and non-permanent resident utilization multipliers are applied, the range estimate for an ambulatory surgery service at TMC is 260 to 733 cases annually.

For purposes of this preliminary ASC feasibility study, Stroudwater has employed an average of the three methodologies’ range estimates. The resulting forecast market potential for an ambulatory surgery service at TMC is 393 cases to 770 cases annually. For comparison purposes, we also included the high end ranges estimate from the use rate methodology calculation (1,259 cases) as a point of reference in the feasibility assessment.

The preliminary ASC feasibility assessment shows an estimated breakeven at approximately 600 cases annually with all capital costs born by the new ASC
service, at 525 cases annually with the equipment donated and at 450 cases annually if the equipment and facility cost is completely offset via philanthropy. These breakeven volumes contrast with the projected range estimate for 2010 volumes of 393 to 770 cases. Clearly, community support for TMC’s mission in the form of relieving the capital expense associated with developing an ASC and accessing services locally will be a significant factor in determining whether these contemplated services are feasible.

<table>
<thead>
<tr>
<th>Expense Line Item</th>
<th>Nature of Expense</th>
<th>Scenario One: All Costs Born by Svc</th>
<th>Scenario Two: Equipment Donated</th>
<th>Scenario Three: Equip &amp; Facility Donated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment Cap Ex</td>
<td>Fixed Annual Expense</td>
<td>$192,075</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Equipment Depreciation</td>
<td>Fixed Annual Expense</td>
<td>$174,614</td>
<td>$174,614</td>
<td>$174,614</td>
</tr>
<tr>
<td>Service</td>
<td>Fixed Annual Expense</td>
<td>$50,000</td>
<td>$50,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Personnel*</td>
<td>Fixed Annual Expense</td>
<td>$188,968</td>
<td>$188,968</td>
<td>$188,968</td>
</tr>
<tr>
<td>Space Costs</td>
<td>Fixed Annual Expense</td>
<td>$70,000</td>
<td>$70,000</td>
<td>-</td>
</tr>
<tr>
<td>Utilities</td>
<td>Fixed Annual Expense</td>
<td>$25,000</td>
<td>$25,000</td>
<td>$25,000</td>
</tr>
<tr>
<td>Overhead</td>
<td>Fixed Annual Expense</td>
<td>$50,000</td>
<td>$50,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Supplies</td>
<td>Variable Cost Per Case</td>
<td>$90</td>
<td>$90</td>
<td>90</td>
</tr>
<tr>
<td>Services</td>
<td>Variable Cost Per Case</td>
<td>$32</td>
<td>$32</td>
<td>32</td>
</tr>
<tr>
<td>Other Costs</td>
<td>Variable Cost Per Case</td>
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<td>30</td>
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<tr>
<td>Total Fixed Annual Expenses</td>
<td></td>
<td>$750,656</td>
<td>$558,582</td>
<td>$488,582</td>
</tr>
<tr>
<td>Variable Costs Per Case</td>
<td></td>
<td>$152</td>
<td>$152</td>
<td>$152</td>
</tr>
</tbody>
</table>

Ambulatory Surgery Market Size Projections

<table>
<thead>
<tr>
<th>Physician FTE Based ASC Projection</th>
<th>Solvent ASC Projection</th>
<th>Use Rate Based ASC Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Range Estimate - 35%</td>
<td>299</td>
<td>620</td>
</tr>
<tr>
<td>High Range Estimate - 65%</td>
<td>545</td>
<td>1,033</td>
</tr>
</tbody>
</table>

Estimates for TMC ASC Annual Volume

<table>
<thead>
<tr>
<th>Scenario One: Breakeven Analysis Fully Loaded Cost</th>
<th>Scenario Two: Breakeven Analysis with Donated Surgical Equipment</th>
<th>Scenario Three: Breakeven Analysis with Donated Equipment and Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,200 per Surgical Case $ (436,256) $ (331,456) $ (174,256)</td>
<td>$1,200 per Surgical Case $ (244,182) $ (139,362) $ (17,818)</td>
<td>$1,200 per Surgical Case $ (174,182) $ (69,382) $ 87,818</td>
</tr>
<tr>
<td>$1,250 per Surgical Case $ (421,256) $ (311,456) $ (146,756)</td>
<td>$1,250 per Surgical Case $ (239,182) $ (119,362) $ (45,318)</td>
<td>$1,250 per Surgical Case $ (159,182) $ (49,362) $ 115,318</td>
</tr>
<tr>
<td>$1,300 per Surgical Case $ (406,256) $ (291,456) $ (119,256)</td>
<td>$1,300 per Surgical Case $ (214,182) $ (99,362) $ 72,818</td>
<td>$1,300 per Surgical Case $ (144,182) $ (29,362) $ 142,818</td>
</tr>
</tbody>
</table>

Notes: * Personnel cost assume fixed staffing complement of 1 RNs, 1 OR techs and 1 manager. TMC should be able to leverage per diem and existing staff to provide a more flexible and efficient staffing pattern than the one modeled above.

Stroudwater believes that joint-venturing an ambulatory surgery service with interested specialists will best ensure that TMC and the community’s investment in this new service would be successful. Specialists expressed significant interest in exploring the feasibility of an outpatient surgery service and also potentially investing in such a service at TMC if it were deemed viable. Stroudwater recommends that TMC pursue broad physician participation. Stroudwater Associates believes that an exclusive arrangement with a single surgical group would unnecessarily exclude potential surgical procedures and undermine the ASC’s feasibility.
Once again, it is important to note that should TMC pursue an “under arrangements” model for this new ambulatory surgery center (ASC), the ASC would be eligible for cost-based reimbursement under RHC, provider-based RHC, or CAH status.
Discussion of Other Service Opportunities

A new TMC facility would represent an important new community resource with the potential for consolidating a variety of health related services into a single “one stop” point of access for San Miguel County residents. Beyond the core services discussed above, a number of other important opportunities are worthy of consideration, as discussed below.

Ancillary Services

Existing non-TMC local healthcare providers have expressed little enthusiasm to participate in a new medical center campus. Interviews were completed with pharmacy, physical therapy, medical practice, and nursing service providers. Concerns were primarily focused on potential location, lease rates, and the desirability of duplicating services.

A facility and campus master plan should anticipate that these attitudes will change once the initial development phase is successfully executed. It would be logical that pharmacy services and physical therapy services in particular be available adjacent to a facility that provides emergency, primary care, and surgical services.

In addition to the above, TMC should also give consideration to providing on-site either directly or via contract oxygen and other retail durable medical device services (e.g. crutches, hospital beds, wheel chairs, etc.) that could be conveniently accessed in this single central location.

Finally, TMC’s services would be enhanced to the extent that bone densitometry and colonoscopy service capacities were available. While financial feasibility analyses were not completed for these two services, bone densitometry could be offered within the existing TMC facility with minor facility adjustments. If a new facility is developed, a procedure room that has the ability to provide colonoscopy examinations should be tested for economic viability, especially given that the recommended standard of care is annual examinations for patients over 50 years old.

Emergency Services

Assuming that a new TMC facility is developed on a new site, the campus plan should anticipate the ability to support Emergency Medical Services including garage space, dispatch, and a heliport for medical evacuation on the site. This would create the opportunity to share some staffing responsibilities in the EC. It would also facilitate ongoing training and integrated planning. In the future, the business merit of shifting Emergency Medical Services from the Fire District to the Hospital District should also be studied from a functional and efficiency standpoint.

Research Services
Dr. Peter Hackett has established an international reputation as a research scientist in the area of high altitude medicine. TMC’s location at approximately 9,000 feet makes it a unique resource for supporting clinical research in this field. TMC should seek to continue to expand its role in supporting the work of Dr. Hackett and the University of Colorado in this endeavor. This brings a variety of advantages to TMC, including recruitment and retention of top-flight clinical staff who also have an interest in research, the potential for grant funding for acquiring new medical equipment that can serve dual roles as clinical and research tools, and the ability to build clinical and research alliances with first tier organizations such as the University of Colorado.

The incremental space costs are likely to include space for research assistants and equipment that has clinical service applications. The potential return on this investment is typically substantial.

Medical Tourism Services

One of ideas identified during this planning process was to consider the development and promotion of medical tourism services. This refers to diagnostic or treatment services that are bundled into a spa or other recreational offerings accessed by the patient and/or a traveling companion.

Specific service ideas included plastic and orthopedic surgery. Several points are worthy of emphasis in this regard:

The current assumption is that it will be a minimum of five years before a surgical capacity will be available at TMC. It will be difficult to develop a specific plan for such services that far in advance.

Telluride is a destination resort of international renown with a loyal and growing following of visitors. However, its location at 9,000 feet which provides such an advantage for research purposes may be a liability in terms of medical tourism services. The impact of altitude on people varies widely, and could be exacerbated when coupled with the stress of surgical intervention. While this does not definitively dismiss this opportunity, it is an obstacle that will need to be carefully assessed.

Destination medical services are generally developed and promoted via a local champion with the reputation, tenacity, and business acumen to grow such a program over time. Currently, Stroudwater Associates is not aware of any clinical champion who has come forth to provide this leadership. Again, this is understandable given the current absence of a surgical capacity at TMC,
coupled with its inability to present as an attractive, contemporary medical facility. Stroudwater Associates recommends that TMC not lead its program development efforts with this concept, but not dismiss it as a future possibility as a new facility and service program evolves.