ESTES PARK HEALTH

ESTES PARK HEALTH
BOARD OF DIRECTORS'
Special Tele Town Hall Board Meeting Minutes – September 9, 2020

Board Members in Attendance
Dr. David Batey, Chair
Ms. Sandy Begley, Vice Chair (via webinar)
Ms. Diane Muno, Secretary
Mr. William Pinkham, Member-at-Large
Dr. Steve Alper, Director Elect

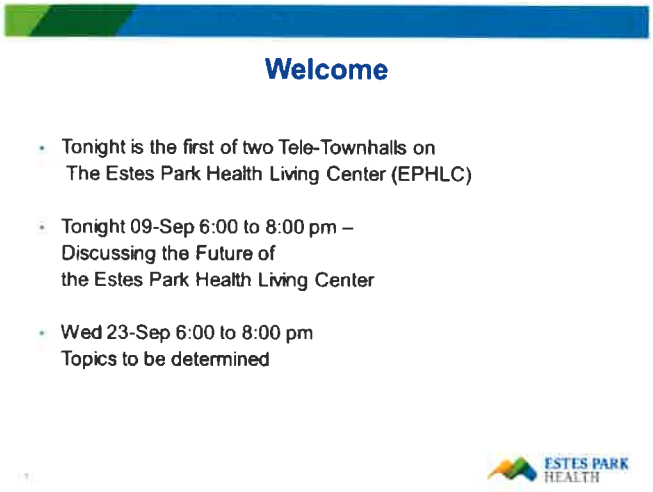
Senior Leadership Attendees
Mr. Vern Carda, CEO
Mr. Tim Cashman, CFO
Ms. Pat Samples, CNO
Mr. Gary Hall, CIO (via webinar)

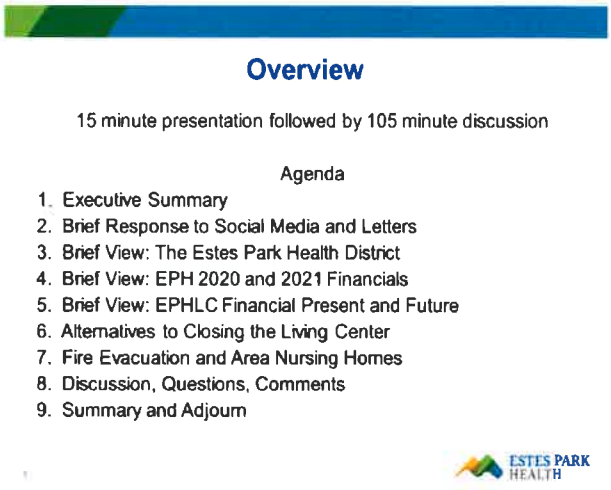
Community Attendees (via webinar)
Cindy Thompson, James and Gail Linderholm, Diane Ernst, Randy Brigham, JAMES P AND ROBIN MCCANN, Dora Flores, Cathy Alper, Ruth Cooper, Mary Bolgeo, Kirsten Mcmillan, Nathan Dick, Jennifer Bass, Franklin Crone, Michelle Billups, Julian Eisner, Michael Prochoda, Tracy McGuire, Melissa Addison, Mark Smith, Scott Boyatt, Karin Swanlund, Drew Webb, Lori Greening, Carrie Taylor, Deb Barlow, Stacey Rangel, Charles Bonza, James Geckler, Kay and Lowell Rosenthal, Glen Kreider, Amber Franzel, Iryna Irkliienko, Jennifer Godfrey, Susan Johnston, Mark Smith, David Fischer, John Cordsen, Peggy Lynch, Carl Henderson, Helen Garcia, Adam Shake, Esther Cenac, Paul Besson, Jane McAfee, Lori Schwartz, Linda Adam, David McAfee, Andrea Rangel, Kathy Littlejohn, Living Center Activity Room PC/TV, Danuta Ziebinski, Natalie Pate, Rod Unruh, Diane Darmody, Orlando Pacek, Robin Brunk, Wendy Rigby, Jennifer McLellan, Teresa McMorton, David Brewer, Bridget Dunn, Don Shelley, Christy Florence, Shayne Hatzenbuhler, Aaron Florence, Carla Ellis, Connie Phipps, Kent Smith, Anne Rogers, Steven Detkowski, Juli Schneider, Julie Lee, Megan Ross, Julie Glasgow, Mandy Fellman, Claire Loughry, Janet Reed, Aileen Campbell, Liv Merritt, Robyn Zehr, Laura Rustin, Charlene De Kehoe, Jeanne Allen, Heather Bird, Jim McGibney, Laura Etling, Corinne Thomas, S D, Brenda Loveall, Zora Thomsb, Wendy Schuett, Rita DuChateau, Pat Cavanah, Marsha Hobert, John Meyer, Ray SAHM, Nelson Burke, Curtis Weibel, Kevin Mullin, Nong George, Gordon Ulrickson, Chris Douglas, Ruth Kelley, Leslie Marshall, Alice Schwartz, Heidi Johnson, John Wray, Cheryl Rivard-Baker, Deborah Barlow, Barbara Gebhardt, Monica Sigler, Karlye Pope, Tony Palmer, Tony and Diane Palmer, Cynthia Sisson, Eric Owen, Anne Morris, Jason Weber, Michael Keilty, Meagan Lopez, Stacy Ferree, Guy Van der Werf, Russ Schneider, Ron Bockhaus, Shirley Barrow, David Standerfer, Deb Kubichek, M Marsha Sypher, Sally Johnston, Helen Taddonio, Lisa Payden, Louise Olson, Linda Newman, Claire Kreider, Judith Schaffer, Barbara Keilty, Philip Moenning, Ann Dinsmoor, Nancy Dietz, Diana Van Der Ploeg, Sharon Colemsan, Jessica Jenkins, LoAnne Forschmiedt, Gerald Mayo, Cindy Leaycraft, Shelley Powers, Wendye Sykes, Ron Keas, Virginia Hutchison, Teresa Binstock, Gayle Hickey, Nancy Matson, Jim &

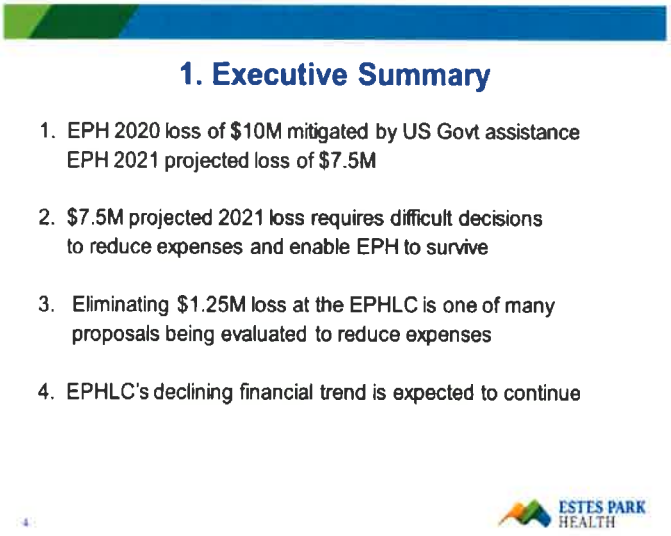
Gail Cozette, Roger & Susan Toy, Tara Schulze, John Phipps, Belle Morris, Larry Leaming, Janine Dawley, Zora Thoms, Elizabeth Sarow, Wayne Newsom, Pieter Hondius, JoAnn Batey, Kay Mitchell, Joseph Curtin, Judith Beechy, Trudy Ester, Pat Cleeland, Wendy Sollod, Leslie Roberts, Zoe Mercer, Deb Dufty, Barbara Widrig, John Cooper and Dona Cooper

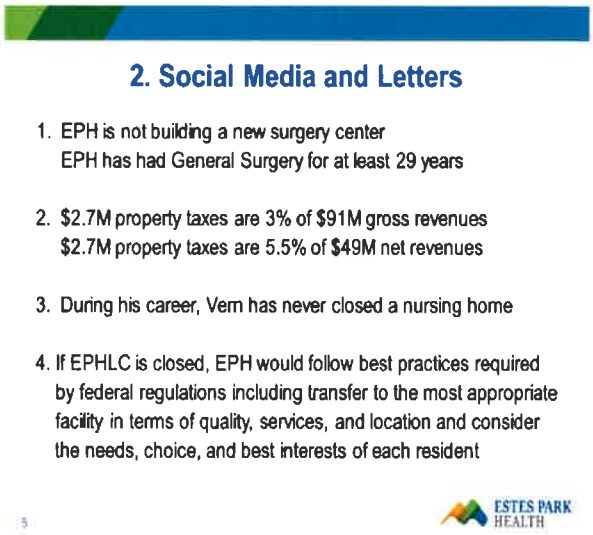
1. **Call to Order**

The Special Tele Town Hall Board meeting was called to order at 6:05 p.m. by Dr. Batey, Chairman of the Board of Directors; there was a quorum present. Notice of the Special Board meeting was posted in accordance with the SUNSHINE Law Regulation.









3. The Estes Park Health District

1. Park Hospital District dba Estes Park Health
   9,735 ballots mailed for 2020 EPH Board Election

2. Chris Akers, Colorado State Demography Office
   Estes Valley is the sum of 4 census tracts
   28.01 Estes Park, 28.02 South Valley, 28.03 West Valley,
   19.03 East Valley

3. US Census Bureau American Community Survey
   2013-2017 5-year Survey data since < 65,000 population
   https://www.census.gov/data.html
   Tables and Maps Section

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3. The Estes Park Health District

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A Diverse Community with Diverse Needs

	Census Tract 19.03, 28.01, 28.02, 28.03		Census Tract 19.03		Census Tract 28.01		Census Tract 28.02		Census Tract 28.03	
	Total	% Tot	Total	% Tot	Total	% Tot	Total	% Tot	Total	% Tot
Total population	13,546		3,725		3,565		6,192		64	
34 years and under	3,789	28.0	939	25.2	1,011	28.4	1,793	29.0	46	71.9
35 years to 64 years	5,785	42.7	2,003	53.8	1,292	36.2	2,477	40.0	13	20.3
65 years and over	3,972	29.3	783	21.0	1,262	35.4	1,922	31	5	7.8
75 years and over	1,499	11.1	208	5.6	541	15.2	750	12.1	0	0
85 years and over	419	3.1	33	0.9	192	5.4	194	3.1	0	0
Median age (years)			53.7		58.1		57		28.7	

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4. Brief View: EPH 2020 and 2021 Financials

1. EPH would lose $10M in 2020 without US Govt assistance
   If $10M in US Govt assistance becomes grants, break even

2. The current best estimate is that, based on expected 80% of usual revenues, without budget changes, EPH would be expected to lose $7.5M in 2021

3. If EPH revenues recover to 90% of usual revenues, EPH would still be expected to lose $5.0M in 2021.

4. Expected 2021 losses require examination of all possible expense reduction options

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5. Brief View: EPHLC Present and Future

1. Estes Park Health Living Center (EPHLC) expected to have a loss of $1.25M in the EPH 2020 budget

2. Expected 2020 $1.25M loss continues a long-term trend:
   Decreasing Revenues
   - 2.1 Declining bed occupancy percent
   - 2.2 Increasing percent Medicaid payments

   Increasing Expenses
   - 2.3 Increasing use of temporary contract labor
   - 2.4 Increasing regulatory requirements

3. Even filled to 38 bed capacity, EPHLC does not have sufficient scale to be financially viable

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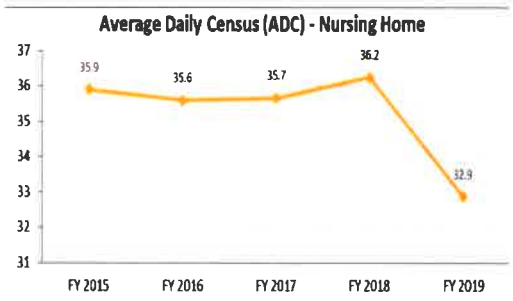
5. Brief View: EPHLC Present and Future



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6. Alternatives to Closing EPHLC

Includes ideas from letters and emails sent to EPH Board

1. Shut down the hospital, keep EPHLC open
2. Sell EPHLC to a national corporation
3. National experts could manage EPHLC to financial health
4. Increase property tax (mill levy) support to cover EPHLC financial losses
5. Establish a sales tax to cover EPHLC financial losses

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6. Alternatives to Closing EPHLC

6. Create endowment that could cover EPHLC financial losses
7. Create a non-profit that could build and operate a new EPHLC facility
8. Get grant funding that could cover EPHLC financial losses
9. Charitable contributions could cover EPHLC financial losses
10. Private pay and insurance could cover EPHLC financial losses

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6. Alternatives to Closing EPHLC

11. Other programs in EPHLC space could generate revenue to cover EPHLC financial losses
12. Increase the EPLC number of beds so, if occupied, EPHLC could break even.
13. Offer new EPLC programs so more beds are occupied
14. Advertise to attract more residents to EPHLC
15. Change staffing to reduce expenses and make EPHLC break even

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6. Alternatives to Closing EPHLC

16. Move EPHLC to a different location, reducing expenses so EPHLC breaks even
17. Gradually close EPHLC to minimize resident disruption.
18. Wait to see if EPH financial performance improves so EPH could subsidize EPHLC again

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7. Fire Evacuation and Area Nursing Homes

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Over the past several days, EPH has started to create and formalize the plan for the evacuation of the Living Center. All nursing homes that were contacted in the outlying communities were receptive to assisting the residence of the Living Center. They also stated that they were receptive to meeting with EPH and Living Center residents and families on how they can assist and potentially take on a resident should the Living Center close.

Questions and Answer Session

Q. In regards to the Board stating they do not know where the January 1 closure timeline came from, the majority of the residents/family members began receiving phone calls from the CNO last week indicating that the LC would be closing and that they had until approximately January 1 before the closure was final. This notification occurred prior to the public notice and to the Board officially voting on the matter. Does the Board feel this was proper? It makes it seem like obtaining community feedback may be useless since it appears the decision was already made.

A. The CNO calling surrounding nursing homes was related to evacuations, in case they were needed. Many of the families the CNO contacted were residents with family/guardians that lived out of state. EPH did not want those families to hear about the potential evacuation and closure through social media or another way other than through EPH. Should the decision to close the LC be approved, a plan must be submitted to the State of Colorado, which can take 2-6 weeks to be approved, at which point then the 60-day notice would be given to residents. EPH has no intention of evicting anyone. Additionally, no one knows what the flu season will bring with Covid. Families were informed that it could potentially be late May/early June before any patients could be moved due to flu/Covid. The calls were also made to give those family members the information on accessing the Tele-Townhalls. The community needs to understand that this is a Board decision, not a CEO decision.

Q. Did you directly communicate with family members that the LC was closing?

A. No. The phone calls were started by saying that we are reviewing the long-term future of the LC.

Q. Is it correct the LC is no longer accepting or considering any new admissions?

A. We are considering admissions on a case-by-case basis.

C. I have been working here for 9 years and I care deeply for the residents of the LC. They truly need our care and may not have anywhere to go. It should be our commitment to take care of them. The community always associates the LC with the hospital. EPH needs to find a way to make it work.

C/Q. My father's dream was to retire here and live in EP and the only solution was the LC. To see it close, is discouraging. He will be devastated if he must leave the LC and Estes Park. Can the government help to offset losses?

A. EPH has been successful in finding stimulus funds, the only funds specifically for the LC amount to $80k, which we expect to receive soon. EPH looks on a continual basis to try to locate government funds.

Q. What got them to the place that the LC was no longer sustainable? It had to of happened over a long period of time.

A. Previously the census was higher. The hospital has been subsidizing the LC all along. The loss of revenue due to Covid virus in the hospital has reduced the ability to subsidize the LC any longer. EPH is examining all areas of the hospital for reductions, not just the LC.

Q. Did we know previously that the LC was losing money?

A. Yes, but the hospital was able to subsidize. Due to Covid, the hospital is no longer able to subsidize. What the LC is experiencing is happening nationally, not just to EPH. We are now communicating this to the community, and we want to make sure we are transparent about what is going on.

Q. The phone call from the CNO was not well scripted call, as she introduced herself and then immediately said, "I'm sure you've seen all the social media" then launched into the discussion about closing the center. Not trustworthy because she said she called other facilities about evacuations, but it was obvious that the conversation was also about relocating residents should the LC close. In Ft. Collins and Loveland, although the CNO states there is an abundance of beds

available, the quality of those facilities is not such that I would feel comfortable placing my loved one. An opening doesn't equal quality care.

Q. Did the number of residents at the LC drop because of Covid or did the bed census remain steady? How many residents have we lost due to Covid?

A. The financial impact is to the hospital overall. 2-3 residents passed during Covid season, but the State closed admissions from March – August. Due to articles and social media posting about the topic of the LC, many facilities specifically asked the CNO about the plans for our LC. She did not initiate the discussion about relocation of residents when calling about the potential evacuation.

Q. When were the calls made to the other facilities?

A. Calls were made starting Monday, September 7 – 8 and approximately 16 facilities were contacted.

Q. Since the LC occupancy hasn't changed, clearly the financial issues are related to the hospital and not the LC. What other areas are you seeing at the hospital as a problem? It seems like there is a lot of hospital space that is not being utilized. Why is that? If you were to terminate the LC what is the plan for that space?

A. There has been a significant decline in occupancy from 2019 – 2020, which is not unique to EPH; it's a nationwide trend. Clinic visits have declined. Surgical procedures, MRI, CT, Lab, and ED visits are all down. EPH has exhausted much of the elective surgery that was pent up demand from Covid. Volumes are soft again and there is concern about rebounding to 80%.

Q. What is the plan for the LC space?

A. EPH does not have any services identified for the LC space. The building is at the end of its life and will require significant capital investment.

Q. Will the LC be used as a homeless shelter?

A. No, the LC space will not be used as a homeless shelter.

Q. Where are you predicting the $5.2M to come from since savings from the LC is only $1.2?

A. The forecast for next year is that revenue will recover to 80%. EPH is working through all areas of the hospital such as staffing, contract labor, supply chain and other areas for cost reductions. There is no guarantee we can make up a $7M loss. At the present time all employees are engaged in problem solving to achieve cost reductions. Wages were rolled back by 10%, PTO freeze implemented, 10% department expense reductions, and time has been spent time working with staffing in perioperative and OB. We have begun analyzing all service lines to determine their viability. We have been meeting with physicians and leaders within the facility to problem solve the projected loss. Any revenue streams we try to grow will take 6-10 months.

Q. What are you plans for expanding swing beds?

A. A swing bed is a bed that can swing from acute to sub-acute in the same room. EPH uses these beds to generate revenue. We are increasing our case management and social work programs and we are trying to increase our swing bed population. Swing bed patients are not taking up space in the LC, they are only in the hospital.

Q. Occupancy of swing beds?

A. The average is 2 a day. The hospital census is around 8-9 a day. EPH has transferred in several swing beds over the past few months. We are licensed for 23 beds, but we do not carry more than 3-4 swing beds, but it depends on the acute care bed census.

Q. Its hard squaring a$10M dollar loss vs. what was presented in the August 31 Board packet. It shows a positive $4.7M after the $10.1M stimulus. The Q2 report was expecting 65%, but actual was 80%. What are we tracking in Q3? What other governmental programs has EPH applied for? It's convenient to make the LC part of the hospital when it comes to losses. The understanding is that the PPP is forgivable if you continue to employee individuals. How will that work if the LC closes and employees are let go?

The financial statement published does not square with the projections EPH is communicating to the public.

A. The CFO offered to set-up a time with Ms. Powers and others community members who have financial questions. Additionally, the EPH auditors and Stroudwater representative will also attend address any questions.

Q. Can the community have an independent audit?

A. EPH is required to have an independent audit on an annual basis. Additionally, the stimulus funds that EPH received is made up of several different stimulus, Cares Act, grants, etc. The only designation for the LC was $80k. EPH does not separate out the funds since we are one entity and one tax ID. We are working on the requirements of submitting for forgives of the PPP and Cares Act stimulus funds. EPH cannot claim these funds on the income statement yet until approval is granted for forgiveness. In 2021 at 80% of revenue and no more stimulus funds

Q. Have previous expansions of services contributed to the financial strain on EPH?

A. The last physical plant expansions were the bond-funded 2006/2007, when the horseshoe-shaped building had the east wing added, the expansion of the Emergency Department in 2009, and the addition of the MRI/CT suite in 2013? In the last 10 - 12 years, services added include Wound Care, Coumadin Clinic, and Orthopedics. Most other service departments have evolved techniques and equipment to stay aligned with modern methods, but are generally the same services offered for many decades by EPH. The laboratory has added analyzers to help with the new COVID world. All those added services (including the radiology additions/upgrades) "pay their way" and do not add to the financial strain of EPH.

Q. From a cost perspective, is there a need or plan for more virtual services in EP? From staffing point to view, has there been discussion around workplace housing in EP to make it viable for people to move here?

A. Due to Covid, EPH has been offering telemedicine. It is a new service line for us and EPH is going to continue it going forward, although we won't spend significant time in expanding the service line as of now, giving the more pressing issues. As for housing, the hospital has several properties around campus to house temporary labor and to serve our needs. There is also a new community workforce housing project going into effect in the spring.

Q. How many people on LC waiting list and how are you processing them for admittance?

A. Currently there is no one on the waiting list. We are evaluating individuals on a case by case basis to ensure we will be able to meet their individual needs.

Q. When you contacted other facilities, don't you think they were more helpful because we were insuring about potential fire evacuations?

A. Yes.

Q. How draining is the UCC costs and rent on the hospital?

A. Volumes at the UCC are running slightly under expectations. If we hit volumes, it will pay for itself. EPH believes the UCC adds value, affordable care and access to care for the community. The rent for the facility will have to be investigated.

Q. Are we searching for a new Chief of Surgery?

A. We are revamping our general surgery line, not seeking a new Chief of Surgery. We will be terminating the general surgery contract and hiring two full-time surgeons that will reside here locally, thus saving the hospital money overall. EPH is moving from contracted model to a service model.

Q. To be forgiven for the $4.8 grant the organization must keep the employees. If the LC closes, wouldn't you need to prove the employment of those staff members?

A. It's a window of time that the government looks at. It is also based on fulltime equivalent. When EPH applied for the funds it used the 8-week period which spanned April – July. Currently we are in compliance. The final regulations have not been published yet.

Q. What other options are you seriously considering besides closing the LC? An in-depth review on the options is requested at the next Tele-Townhall.

A. EPH has identified 18 options that were seriously considered. Potentially review all options at the next Tele-Townhall in depth.

C/Q. EPH says it is committed to transparency, but if you watch the video of the last Board meeting it shows that the Board already decided to close the LC. No Board email addresses are listed on the EPH website. Families were notified they had to do something by January 1 and now the Board and senior leadership is saying that is not happening. How much do the Hospitalists cost EPH? How much did the PR firm cost EPH? How much did it cost the hospital in referrals when specific physicians were lost?

A. The Board invited Gerald to attend the Financial workshop to have all his questions addressed.

C. We talk a lot about the aging at home trend. For most people it is a last choice to enter a nursing home. Additionally, the quality of care of some facilities in the valley are not the same as the LC. We are not Ft. Collins, Boulder or Denver and we have a special community here. We are one of the few nursing homes that have been Covid free and that is because of the staff and quality of care provided. We should try and keep this facility open at all costs. It doesn't make a lot of sense when you talk about having empty hospital beds and then you speak of closing the LC which provides revenue to the organization. Also, seems unbelievable that the hospital has no plans for the large space should the LC close. You're asking the community to trust you regarding the financials and the drain of the LC on the hospital.

Q. You added four residents after Covid restrictions were lifted. Doesn't that mean that census could be grown to a "profitable" or at least break-even point?

A. For both decades of this millennium, through multiple boards and administrations, through internal and external management in the LC, the LC has never broken even. It is unlikely that this pattern can be changed in the future.

C. The CNO identified herself when she called, gave us an opportunity to ask questions and shared the hospital's potential closure of the LC. Thanked the Board for their time and fielding questions from the community on this topic.

Q. Nurses who work in the facility are extraordinary. Is there a chance that you could call in a consultant to review the efficiency and effectiveness in order to try to keep the LC open? The loss of Nursing Assistants and other staff that will be displaced by closing the LC will be detrimental.

Additional questions/comments received via the Go to Webinar question board and/or email:

Q. When did the idea begin to potentially close the LC?

A. There has been discussion for decades of the challenges of maintaining a nursing home in a small critical-access hospital, through many different boards and administrations. Most small-town or critical-access hospitals have never tried to support a nursing home, and those who have in the past have generally let go of that business line over time, for the same reasons that EPH has struggled with making this work. Now, facing a highly uncertain future caused by the pandemic revenue depression across all hospitals, it behooves the community to consider the future of Living Center and other perpetually negative business lines, in order to ensure that Estes Park can maintain a viable hospital and core ED and EMS services.

Q. Why consider closing the LC now? Why is the declining financial situation expected to continue?

A. While there are other financial factors, the great majority of the reason for looking at the LC (and other business lines) now are the dangerously reduced revenues from the COVID pandemic. There is great uncertainty for 2021, across healthcare and other businesses. Even if a successful vaccine is produced, will it work for evolving strains of COVID-19? Will all citizens

take the vaccine? The general expectation across the healthcare industry is that the depressed revenues will continue at least through 2021, due to generally slower business across all industries, less travel, restrictive social interaction, fear of seeking care that is not emergent, and many other factors. There is concern in the healthcare industry (and other industries) that the COVID depression of revenues may continue longer than 2021. If, as expected, revenue projections remain depressed due to long-term pandemic issues and EPH does not act very soon, we may reach a point in 2021 where we can no longer pay staff and expenses.

Q. Has EPH had any buyout offers (including or not including the Living Center)?

A. EPH has not received any buyout offers and has not sought any buyout offers. Over the decades, the various boards and administrations have stated the desire to remain an independent community hospital. The consensus across the Board and administration is that a larger hospital system would first look at EPH business lines that lose significant revenue and close those lines. This does not mean that a buyout should not be considered as an option now or in the future, this is just a statement of the past consensus.

C. MCR/MCD does not support any facility.

A. That is very true, and that's one of the reasons that with all the political forces reducing and restricting this funding, all critical-access hospitals are challenged and struggling even more in recent years.

Q. What is going to fill up the former Rehab department?

A. We have moved several of our hospital outpatient services to that area. The infusion/chemotherapy patients now enjoy the nice sunlight and view from that space. Our Coumadin Clinic and our Respiratory Therapy have moved down there, and our Cardiac Rehab still occupies that space. Shortly, we will move our Wound Care services down there. In every case, this means that patients coming to those departments will not have to go to the hospital inpatient floor for those services.

C. We should close the Urgent Care Center, break that contract, and move our services back here

A. EPH has been very space-challenged in recent years. As we've added Wound Care, Coumadin Clinic, and grown in other clinic and hospital outpatient services, we've forced patients to come into inpatient hospital areas to receive these services, as well as chemotherapy & infusion, respiratory therapy, and other services. Moving the rehab area has allowed EPH to move those various hospital outpatient services to a much more patient-friendly area in the vacated rehab location. In addition, our clinic, with the addition of internal medicine and family practice over time to serve our older and family population, has been highly constrained, with physicians forced to share offices and alternate schedules. The movement of some specialties to the Urgent Care Center has provide much-needed space for our clinic physicians to operate their practices in a fashion that better accommodates our patient needs.

Q. What will we use the Living Center space for if the Living Center does close?

A. There have been no discussions yet regarding alternate use of this space.

Q. Has the senior leadership team had pay reduced or frozen?

A. Phase 1 of cost-cutting measures (starting in early June) included at 10% cut of salaries of all exempt staff (all leadership team members and some others) and physicians.

Q. How many properties does EPH own? Are they mortgage-free, do they generate income, how are these used, and could they be sold to generate income?

A. EPH owns three houses to the north of the hospital, outright, no mortgage. EPH owns four condominiums northwest of the main building. Only one of the condos (and none of the houses) generates income: this is the one that has our two-bedroom sleep lab. One condo houses the Foundation and the durable-medical equipment managed by the Estes Park Quota Club. One of the condos houses the on-call Birth Center nursing staff. Another is used for temp housing as needed. The three houses to the north: One house our EMS on-call/on-duty team and the other

two are used for various on-call staff for the ancillary clinical departments. Selling these properties would result in significant additional housing/hotel/travel expenditures for EPH and would only provide budget funding for a fraction of a month for EPH.

Q. How many new admissions in LC since the COVID restrictions were lifted?

A. In the last two months, EPH went from a census of 25, to a census of 29, and currently is at 28.

Q. Have families been notified that they need to look for a new home?

A. Eighteen of the current 28 residents' families have been notified of the proposal. They have not been told to look for a new home, as this is still just a proposal.

Q. What is the likely closing date if the decision is made to close the Living Center?

A. No date has been discussed or set. EPH would work humanely with residents and families to find accommodations for all.

Q. How are you going to continue to have enough money year to year for the Living Center?

A. The Living Center has never been a break-even or better service line and has always been subsidized. This is very rare for small-town, critical-access hospitals to still be maintaining this service line, and it is expected that, given the challenges of staffing and housing and financial factors in Estes Park, the Living Center will continue to be a significant financial strain to EPH.

Q. Can additional tax revenues be provided to fund the Living Center?

A. EPH has not yet explored that with the town and community. Given the losses of the town and most businesses due to COVID, the competition for tax revenue dollars in EP, and the long-term prognosis for extended depression of revenues in 2021 and possibly beyond, there may be significant opposition to additional funding from tax revenues. Also, this is highly unlikely to help with the 2021 funding, and the potential to exhaust EPH.

Q. What about the line of credit that EPH has at a local bank?

A. The line of credit, if tapped, would only fund EPH expenses for portion of a month, and repayment at interest would be required. This would not be a long-term financing option for the Living Center or for EPH.

Q. Is the portable MRI still in operation?

A. No, EPH built a suite to house a permanent MRI and CT to replace the once-a-week MRI truck and to provide onsite fixed-CT services (rather than just portable). The value of having the in-house CT is immense for emergent situations (strokes, etc.) and we have significant business from the community for both services.

Q. What alternatives are there for long-term care in EP?

A. For nursing care, there are no other options in Estes. Good Sam's does provide an assisted-living complex.

C. Our hospital is an acute care hospital not a do-all-things hospital. The core business of EPH is the acute care, the emergency department, the Emergency Medical Services (ambulance), the outpatient clinic, and the ancillary clinical departments (lab, radiology, pharmacy), and the support services for these. The addition many years ago the nursing home began contributing to long-term financial strain on EPH.

Q. Why is EPH in poor financial condition?

A. EPH has historically been close to break-even, slightly (1 – 2%) over break-even, or under break-even. In most cases, the hardship years have been weathered with assistance from the tax revenue, which also helps provide capital for facility repair, equipment upgrade, etc. The very significant losses during the first wave of the Covid closures (March – May) and the continued losses since are the main factor for the financial hardship. EPH traditionally spends some capital each year as mentioned above. In addition, before the Covid crisis occurred, EPH funded the conversion to the Epic electronic-health record (hosted by UCHealth), provided some funding for the internal design of the Urgent Care Center, and had a hiatus of surgical services due to some necessary equipment replacements. These further constrained finances before Covid.

Q. Where did you spend the $10M received from the government?
A. These funds have been used to offset the Covid losses, and hence have contributed to operations across all departments.
Q. Can you get $1.4M from the Foundation? Historically, the EPH Foundation has provided funding for various equipment needs on an annual basis. Even if the Foundation were to be able to produce $1.4M in a particular year for LC funding, the giving pattern in Estes Park does not indicate that this could be annually sustainable.
Q. Have you considered submitting a referendum question to the taxpayers based on options for hospital finances?
A. This seems to have surfaced suddenly and created a great deal of anxiety and confusion in the community.
Q. With our aging population--I believe our median age in EP is 58 or 59. I think our nursing home is an asset to our community and will only become more necessary as time goes on. Why is the declining financial trend for the nursing home expected to continue?
Q. How many properties does EPH own & what can you do to sell those for financial support for the LC?
Q. If a closing decision is made, what is the likely date for the closing period?
Q. What is the prospect of increasing the property tax for the District?
Q. If you can save $1.25M from the LC where will the $5.25M come from?
Q. What is the total annual running cost of the LC?
Q. Has senior leadership pay been reduced, frozen, etc.? If you have contracts could you not attach a codicil?
Q. What other departments are you considering closing?
C/Q. I was informed by a family member that the LC had stopped taking new residents - short-term rehab or long-term rehab - and the reason was Covid. This family member needed a nursing home and had tested negative yet was going to be sent to Loveland or Longmont where the risk of Covid is much higher. Now one of the reasons cited for the closing is the low occupancy rate. Have you been using the Covid situation as an excuse to keep your residency rate low?
Q. What will happen to the new beds that were purchased by the Foundation for PPLC last year?
Q. How many new admissions have they approved in the last 6 months? Several doctors at EPH told us that the LC was not accepting any new patients. Should this discussion with resident families be taken offline?
C. No communication was received by me that the LC is closing for certain and that deliberations were ongoing. However, I am looking at other care centers at would be most suitable for my mother and other family.
Q. Has there been any discussion or detailed explanation of why the population at the nursing home has decreased? Why has it decreased when the demographics of the area are not getting any younger?
Q/C. If they are accepting new residents on a case by case basis, how many in the last 6 months did they accept and how many did they refuse? And if all the doctors at EPH think they are not accepting new residents; they may not even have a chance to evaluate this on a case by case basis. Bottom line - don't use low residency numbers as a reason for closure.
Q. Is a mill levy or sales tax increase a viable answer to this problem?
Q. Why is one of the Board members not wearing a mask?
C/Q. EPH benefits from secondary income from LC with respect to labs, radiology procedures, physical therapy, emergency room visits, hospitalizations, surgeries, specialist consults, primary care physician income, etc. With the loss of the LC, how much revenue will other EPH departments suffer?
Q. Why aren't you clearly showing itemized expenses for the Living Center?

Q. If you have added 4 residents in the last few weeks, can't you project from that to getting back to a healthy occupancy rate?

C. It's important as a taxpayer to know that all options for the hospital's financial health are on the table, are being vetted and that some consideration is being given to a public question to guide the vote of the directors.

Q. Has EPH had discussions with University of Colorado Health about becoming part of their system? It would provide EPH with greater access to specialists, IT, management, nursing coverage, EHR... and UC benefits from referrals.

C. Close the new rehab center and urgent care immediately and break the lease. There is space for these at EPMC.

Q. Many elderly post-surgical and hospitalized patients require a prolonged rehab stay to regain their independence and return home. Not all these patients meet Medicare criteria for rehab swing bed stays on the med-surg floor, and hence, require rehab stays at a nursing home. With the loss of LC, how do you plan to address this scenario? Furthermore, many hospice patients require additional supervised care at end of life. How do you plan to address this scenario if the LC is closed?

Q. The public wants the answers to Shelley's excellent questions about financials. If the $10M goes on the books, EPH starts next year with a $2.5M surplus. Is that correct?

Q. Does it really cost 100,000 dollars to fill an LPL position?

Q. How much revenue has moved from the emergency room to the urgent care?

Q. How do you not know the lease cost of the new UC facility?

Q. Option 19. Program of All-Inclusive Care for the Elderly (PACE). I will follow up with Diane and David directly.

Q. How are you going to continue to have enough money year to year to be confident that PPLC can stay open for a long period of time?

C. Please put out the real numbers in lay person language based on your financials for the entire group. Just give us projected income, projected losses, and stimulus money either received or in process.

Q. As discussed, our taxes pay a portion of the EPH revenue. If the community wants to further step up and allow tax increases to keep both the LC and EPH as viable entities, how much (in percentage increase vs our current EPH related tax) will taxes need to be raised to cover: 1) the LC losses and 2) total EPH losses for 2021?

C. We would like to offer support to the leadership team and BOD

C/Q. Thank you for letting me ask my question, but no one addressed my comment/question that if you've added 4 more residents in just the last few weeks, why can't you develop a plan for what it would take to get the Living Center back on strong footing?

C. You will need to do some work to overcome the fact the people now think you will close - your waiting list won't rebound until you do.

C. I think the history of capacity should be reviewed for the Living Center to provide data on how much it is used. I think the Living Center should maintain some capacity to serve the current and future residents. If there is space that can be converted to another use while keeping the Living Center available, that would be ideal. Is it possible to use grants to cover costs? Would the status of the Living Center need to change? These are just questions to consider how the Living Center can remain open for those people in the community that live there.

C. I am concerned that when I looked at Medicare Compare for Nursing Facilities, Estes Park Health Living Center scored **1 STAR on a 5 Star scale.** (Health rating was 2 Star, no available information on staffing, and 1 Star on quality measures). These are not good ratings, and it does make me wonder if we, your community, are only being given very minimal information about

what is really causing the administration to consider closing the care facility. Please truthfully respond.

Adjournment

The meeting was adjourned at 8:15 p.m.

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