

**TETON VALLEY HEALTH CARE**  
**SUB-COMMITTEE: Hospital Structures Committee**  
**TVHC Board Room**  
**12/15/09**

**Attending: Mitch Felchle, Dr. Eric Johnson and Janine Jolley.**

**Absent: Michael Whitfield, Kathy Rinaldi, Roger Emerson, Stacy Stewart.**

Meeting was called to order @ 8:46 am

**ADDITIONS TO ADGENDA:** Tax Levy input from team members attending.

First, the team went over all the member summaries which had been compiled before the meeting into one document. Out of the current committee, there were 4 individual summaries turned in. We made minor changes in the final summary document—changed one typo and corrected a few factual errors made by members. (This summary is attached)

Next, the committee voted “OUT” their least desirable choices. These structures were ones the team felt were not good matches for our community or did not help solve the problems that we have.

**STRUCTURES WHICH WERE VOTED OUT:** For Profit, and eventually, we need to move from the County-Owned model.

Reasonings given were factual and complete: For Profit—not a good fit for community, hard to find investors in a small rural hospital that is older, already asked EIRMC and St. John’s if they were interested purchasing with last board and no interest, bad investors climate.

**COUNTY OWNED:** The Frasier Supreme Court ruling has made it very difficult for county owned and operated hospitals to get the funding they need for capital expenditures. Our hospital eventually needs to move away from this model because we have expenditures we need to be funding for which would be difficult to say are “urgent”, necessary, and normal”—and can be spent within one budget year. Unless a roof is caving in on top of the hospital, it is not possible to meet the “urgency” requirement to pass bonds or get a simple majority vote on expenditures with need to pay for over 20-30 years.

It is difficult to keep going back to the public. Comments were made that our clinic space is very limited and renting is not a good option for us to continue doing. We either need to own our space or build a new space eventually. The hospital was built in the 1960’s and is not up-to-date. The clinic was built in the late 1930’s early 40’s, and is out of date.

The team then moved to discussing the options they DID like. The hospital district and the 501c3 model were the favored choices.

**HOSPITAL DISTRICTS:** It was discussed that hospital districts work well in rural communities and that they have a feeling of community ownership. Kootenai County uses one quite successfully for their hospital. We know districts can work here, because of how well the library district works. The library functions beautifully, and never uses all the money that they are allowed from the levy.

The difficulty with districts was discussed as well. The biggest downside we felt with a district was that it would leave out Alta because they are already included in the Teton County Wyoming Hospital district. There are possible governance issues with these because people run for office and it could invite strong political agendas. We have seen this with our neighbors from over the hill and they can be a nightmare.

Hospital districts are difficult to pass—especially in this economic climate, as they require a 2/3 vote.

It was also pointed out that districts have debt limitations of 2% of market value of real estate.

**501(C)3 OPTIONS:** It was pointed out that that Bingham model does not require a public vote. A tax levy is still a possibility, but it would not be wise to use one unless there were dire circumstances. It was felt that there would be a “Playbook” existing on a shelf that could be used since so many hospitals are going to the same structure.

\*All team members felt that based on the information we had, that the Bingham model of the 501C3 was the model we should use, and that we felt we have explored this as far as we can. At this point, we felt we should turn it over to the BOCC and the BOT of the hospital for their discussion and deliberation on.

M. Felchle had questions about the 501C3 model due to the large number of contracts and pension plans that would have to be gone through.

He pointed out that there is nothing budgeted in for a changeover to a different structure. How much this would cost was a question we decided to ask our attorney.

It was generally felt we could generate enough revenue to keep the hospital in the black but the team was concerned that we would have NO way of raising enough funding for capital expenses such as a CT scanner (500K-750K) and MRI , purchasing the clinic or building @ another space, or other major expenditures.

All agreed that these complete issues of financial issues should be completed at the board level with BOCC involvement. We need to have the BOCC involved more so they do understand what is involved, and why we need a change. Hearing it after the meeting is not the same as attending a meeting and participating.

All agreed that the need to clearly educate everyone---in legal, board, community of the Frazier act and why it has changed County-owned/operated structures adversely.

The potential need for another tax levy was brought up and discussed. J. Jolley pointed out that we need to make it very clear with the taxpayers that we are doing much better and do not expect

to keep coming back to our community like an adult child to their parent for handouts every so often . WE feel that this is the last levy we should need to get us through our bad moments of the past.

All felt that unlike the last levy passed, where taxpayers voted and then found out after that services were being cut and clinics closed, that we have no big surprises we expect to find now. We are generating income. All felt that the hospital was doing a much better job of being in the black and we were retiring debt. The problem is, is that we ARE still on thin ice, and if we have a few bad months in a row where we don't have much revenue, it could really throw us off.

The team took a break from 10 am to 10:10 am. Afterwards, the team came back on and prepared questions on the 31-3515A (Bingham Model) 501C3 plan for Mike Stoddard from Hawley-Troxell law firm.

The team decided that with our limited information that we would support the BOT and BOCC in asking for another tax levy in 2010, should they decide to do so. We do not have all the political, financial, and legal ramifications to make the ultimate decision. This decision, with our recommendation, needs to be studied more under the BOT and BOCC.

**HAWLEY TROXWELL INFO:** At 10:25 am, Mike Stoddard was brought on the line and answered questions. He was asked his background in structures. He is a partner in the firm. He has a strong background in helping hospitals change over to the 501C3 structures. He was very articulate and had the answers to our questions. He is in the process right now of helping two hospitals make the change to the Bingham model of 501C3.

M. Felchle asked mechanically how difficult it was to change over. M. Stoddard replied that it was very time consuming and it took a lot of Admin team time, accountants, law firm time. There would have to be time spent on every contract within the hospital to change it over. It is a reasonably daunting task, but one that Is possible, and realistic. There are licensing issues, Medicare/caid hoops to jump through. Pension plans such as our 401A defined benefit plan are difficult and Mike Stoddard suggested we talk to Bob Thomas who is an expert on pension plans conversion.

The question was asked of a real cost estimate for conversion. There is some ambiguity, as each hospital has its own issues to deal with, but M. Stoddard felt that we could assume it would be between \$100K and \$150 K to changeover. Minidoka hospital that just changed over to this same structure spent around \$125 K. The GOOD news is that the Idaho Health Authority kicks in up to 50% for hospitals that want to convert. Their money comes from years and years of loans they have made to hospitals. It is not tax money. It is interest on loans made that they are able to grant to hospitals.

M. Stoddard stated that on 5/8/07 he presented an IHA sponsored seminar with a typical FAQ type list on it for hospitals considering a change.

The main difference M. Stoddard saw with the Magic Valley model or regular 501C3 is that they chose to partner with another hospital (St. Luke's). St. Luke's took 5 of the 9 hospital board member seats. This took local control away. This is one reason why our team felt that the Bingham model was better, is that the current hospital board could and is encouraged to stay on. After the " is established, the board can create their own bylaws for how board members are chosen, staggered, or removed.

In the Bingham model of the 501C3, there must be a board member from each incorporated area within the boundaries. Then there must be one general member from an unincorporated area.

From a political perspective, we must help our community understand that we are not "giving away" our hospital. It would be a lease, or we could sell our assets to the 501C3. In any case, if we do not operate the hospital as a true 501C3, the county has the right to take back over the hospital.

The beauty in this model is that even though there is NO REQUIREMENT for public meetings, it is possible to be as transparent as the board would like to be. Meetings can still be public, the BOCC can still be asked to review the budget for each year. It is a general suggestion in this type of model that a BOCC member be asked to be on the board.

Extra revenue produced is plowed back into the hospital facilities.

One difference between a county-owned facility and a 501C3, is there is a possibility of unionizing within the hospital...although it has only been done by one group of nurses who formed a nursing union at one hospital.

Tort Claims are also different, in that with a County owned model, the limit is \$500,000, or up to the limit of the insurance the hospital has. Any claim must be made within 180 days.

With a 501C3 under the Bingham model, it is easy and inexpensive to increase the limits on insurance. There are minimal costs to do this, and it has not been a big issue with other hospitals.

The Frazier act was discussed as being the main reason we need to change over from a county-owned model to a non-profit model. The main problem it brings is the inability to borrow for long term debt. If we wanted to buy or build a clinic, we cannot do this under a county model, because all expenditures must be made within one year.

M. Stoddard said there are a few ways to get around this with a county model, but that they can be difficult.

1. Pay with cash.
2. Have an election, and get a 2/3 supermajority to pass a bond for expenditures.
3. Argue before a judge that the needs of the hospital are ordinary and necessary, and URGENT. This would be very tough to find a judge willing to fight around the Frazier act.

4. Joint Ventures between investors and the county. This also is tough, because no long term debt financing can be held by the county. The debt must be held by the investors instead.

The question was asked about what the trend is in the state of Idaho with hospitals. M. Stoddard gave the answer that the trend since 2006 when the Frazier act was passed, is that four hospitals have already converted to a 501C3, two more are in the process. There are now 18 hospitals left with different structures other than a 501C3. In rural communities like ours, small hospitals are normally supported by the taxpayers.

We finished our discussion with M. Stoddard @ 11:10 am.

In summary: Our team present, with the feedback given by other committee members, felt that we should look to moving to a 501C3 31-B515A (Bingham) model for the following reasons:

- a. The Frazier act has made it impossible to function under county owned model
- b. 2/3 super majority vote for capital expenditures/bonds is challenging
- c. The county commissioners (BOCC) can approve this changeover with a simple vote.
- d. This model does not completely cut us off from county funding or oversight. It is a lease.
- e. If we do not operate it clearly as a 501C3, then the county can re-take the hospital over.
- f. The taxpayers under this model do not have to pay for another election to change over to a different model.
- g. Ensures BOT continuity and local control.