AMERICA'S ESSENTIAL HOSPITALS

Board of Directors Meeting

March 31, 2014

Westin Georgetown | Washington, D.C.

AMERICA'S ESSENTIAL HOSPITALS

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AMERICA'S ESSENTIAL HOSPITALS

Agenda
Board of Directors Meeting
March 31, 2014
11 am – 5 pm

11 – 11:05 am	Call to Order and Disclose Conflicts of Interest (Mr. Traylor)	
11:05 – 11:10 am	Approve Consent Agenda (Mr. Traylor)	ACTION
	• December 2013 Minutes • October 2013 Minutes • New members	
11:10 – 11:25 am	President and CEO Report (Dr. Siegel)	
11:25 – 11:35 pm	Review and Approve Institute Board Nominations (Mr. Traylor)	ACTION
11:35 – 11:45 pm	Nominating Committee Report (Dr. Walker)	ACTION
11:45 – 12:30 pm	Membership Committee Report	
	• New Dues Structure – Part 1 (Mr. Lopez and Staff)	
12:30 – 1 pm	Lunch	
1 – 1:45 pm	Membership Committee Report	
	• New Dues Structure – Part 2 (Mr. Lopez and Staff)	
1:45 – 2 pm	Education Committee Report (Mr. Belzer)	
2 – 2:10 pm	Policy Advisory Committee Report (Dr. Walker)	
2:10 – 3:10 pm	Policy/Advocacy Update (Dr. Feldpush)	
3:10 – 3:25 pm	Break	
3:25 – 3:40 pm	Impact Studies: Value Based Purchasing and Readmissions (Dr. Engler)	
3:40 – 3:55 pm	Finance Report (Mr. Lopez)	ACTION
3:55 – 4:10 pm	Rollout of New Association Website (Mr. Graziano)	
4:10 pm	Adjourn	
4:10 – 5 pm	Executive Session	

America's Essential Hospitals Board of Directors
2013-2014

CHAIR
Thomas P. Traylor, MBA
Vice President, Federal, State and Local Programs
Boston Medical Center

CHAIR-ELECT
William B. Walker, MD
Director and Health Officer
Contra Costa Health Services

SECRETARY
Johnese M. Spisso, MPA, RN
Chief Health System Officer, UW Medicine; VP for Medical Affairs, UW
UW Medicine

TREASURER
David S. Lopez
President and CEO
Harris Health System

PAST CHAIR
Stephen W. McKernan
CEO, UNM Hospitals
UNM Hospitals

AT-LARGE MEMBER
Betsey Bayless (2012-2014)
President Emeritus
Maricopa Integrated Health Systems

Michael B. Belzer, MD (2012-2014)
Medical Director and Chief Medical Officer
Hennepin County Medical Center

Reginald W. Coopwood, MD (2012-2014)
President and CEO
Regional Medical Center at Memphis (The MED)

Steven G. Gabbe, MD (2013-2015)
Senior Vice President for Health Sciences, CEO
The Ohio State University Wexner Medical Center

Timothy M. Goldfarb (2012-2014)
CEO
UF Health Shands Hospital

George B. Hernandez, Jr., JD (2012-2014)
President and CEO
University Health System

Michael Karpf, MD (2013-2015)
Executive Vice President for Health Affairs
UK HealthCare

Santiago Muñoz (2013-2015)
Chief Strategy Officer
UCLA Health System

Jorge Ramon Orozco, MHA (2012-2014)
CEO
Rancho Los Amigos National Rehabilitation Center

Sheldon M. Retchin, MD (2012-2014)
CEO, VCU Health System
Virginia Commonwealth University Health System

EX OFFICIO
Irene M. Thompson
President and CEO
UHC

AMERICA'S ESSENTIAL HOSPITALS

2014-2015 Association Board Meeting Dates

Monday, March 31, 2014
11 am – 5 pm
Westin Georgetown
Washington, DC
Held in conjunction with April 1-2 Policy Assembly

Tuesday, June 24, 2014
11 am – 5 pm
Westin Riverwalk
San Antonio
Held in conjunction with June 25-27 VITAL2014

Tuesday, October 28, 2014
11 am – 5 pm
Liaison Hotel
Washington, DC
Held in conjunction with October 29 Innovations Summit

Monday, March 16, 2015
11 am – 5 pm
Westin Georgetown
Washington, DC
Held in conjunction with March 17-18, 2015, Policy Assembly

Tuesday, June 23, 2015
11 am – 5 pm
Westin Gaslamp Quarter
San Diego
Held in conjunction with June 24-26, 2015, VITAL2015

Board of Directors Meeting Minutes
Wednesday, December 11, 2013
Meeting by Telephone

Attendees: Betsey Bayless; Michael Belzer, MD; Steven Gabbe, MD; Timothy M. Goldfarb; George B. Hernández, Jr., JD; Michael Karpf, MD; David Lopez; Stephen W. McKernan; Santiago Muñoz; Jorge Orozco; Sheldon Retchin, MD, MSPH; Johnese Spisso, RN, MPA; Irene Thompson; Thomas P. Traylor; William B. Walker, MD
Excused: Alan D. Aviles; Reginald W. Coopwood, MD; Arthur A. Gianelli, MA, MBA, MPH
Staff: Rhonda Gold; Bruce Siegel, MD

Board of Directors Chair Thomas Traylor called the meeting to order and stated that the agenda was for the board to review the 2013 year-end projection and approve the 2014 proposed budget. He turned the meeting to David Lopez, treasurer, for presenting financial materials.

Lopez stated that the finance committee reviewed and approved the 2013 financial projection and 2014 proposed budget. He stated that the 2013 projected financial update reflects projected income of $8.07 million, $7.2 million in expenses, and an operating surplus of $877,000, before rebranding costs ($175,000) funded from reserves. The projected surplus is $77,000 less than last projected in October because of an allocation of more staff salary and fringe costs to the association, rather than Essential Hospitals Institute. After accounting for last year's beginning net assets, staff projects total 2013 net assets of $6.13 million, an increase of $735,000 from budget. There were no questions asked.

Lopez presented the 2014 proposed budget, which includes an additional $100,000 contribution to restricted net assets to fund the anticipated expenses for the association's office relocation. This contribution is in addition to the $250,000 set aside in 2012 and 2013. Gold stated that the proposed budget reflects ongoing activities to support the organization's new, five-year strategic plan. She stated that activities related to quality, innovation, and adaptation are reflected in the Institute's budget as part of the Research Center and Transformation Center work.

Lopez asked Gold to provide an overview of the proposed budget and to address board member's questions. Gold stated that budgeted 2014 revenue is $8.70 million, an increase of 8 percent (or $635,100) from the 2013 projection and approved budget. Of the $8.70 million, $5.15 million represents membership dues, which includes a 5 percent automatic dues increase; three new members for the full year; and two new members at half a year. Budgeted expenses of $7.83 million are 9 percent more than the 2013 projection, but are in line with the 2013 budget. The budgeted 2014 operating surplus is $877,000, before rebranding expenses ($100,000) funded from reserves—the same level as the 2013 projected operating surplus. After accounting for investment income, budgeted total net assets are $6.95 million, of which $350,000 is restricted for the office relocation. Gold reported that this budgeted ending net asset balance represents

close to one year of the association's operating expenses in reserves, a level consistent with the auditors' recommendation.

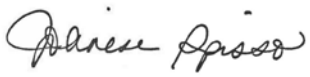
Bayless asked for an update on the status of membership recruitment, to which Siegel responded that eight new members were recruited in 2013 and he expects four new members in early 2014. There were three membership losses in 2013, including two members that exited the inpatient business and one member that disengaged from the association. Siegel said the organization will undertake a dues restructuring initiative and present initial draft recommendations to the board for review in spring 2014, with the expectation of approval in the summer and processing of 2015 invoices in November. The goal of this restructure is not to gain new dues revenue, but to address parity issues and help with membership recruitment. Lopez suggested giving advance notice to members to allow time to adjust their budgets. Siegel agreed this will be important.

Lopez stated that the only budget uncertainty at this point is the cost of the office relocation. Gold and Siegel said staff will keep the board informed of potential costs. Lopez concluded that with the association's healthy bottom line, he would recommend the board's approval of the 2014 proposed budget. Lopez made a motion to accept the 2013 financial update, Spisso seconded the motion, and the board unanimously accepted the update. Traylor made a motion to approve the 2014 proposed budget, including a contribution to restricted net assets for the association's future office relocation. Walker seconded the motion and the board unanimously approved the 2014 proposed budget.

Gold presented a long-range financial forecast through 2017 for the association and Institute. She said the purpose of the forecast was to project the amount of revenue enhancements or expense reductions the organization would need to maintain an annual 5 percent profit margin. She reviewed the budget assumptions, which included a 5 percent annual dues increase and net gain of two full members per year; a 2 percent annual increase in external sponsorships; the rollover of existing grants; $260,000 to $300,000 in new grant funding; and the renewal of the Partnership for Patients contract. She stated that expenses are inflated by 3 percent to 4 percent annually and do not reflect future office relocation and space build-out costs for 2015. To achieve an annual 5 percent profit margin through revenue enhancements, expense reductions, or a combination, the association would need to achieve an approximate 2 percent to 3 percent reduction in overall annual operating expenses. Gold stated that this information is a guide for the leadership team. Questions were addressed and the financial forecast and budget discussion was completed.

Siegel provided a brief overview of the recent congressional budget agreement and answered questions. The meeting was adjourned.

Submitted by:



Johnese Spisso, *Secretary*

AMERICA'S ESSENTIAL HOSPITALS

America's Essential Hospitals
Board of Directors Meeting Minutes
October 1, 2013

Board Members Present (15):	**Board Members Absent (3):**	**Staff Present (11):**
• Thomas Traylor – (Chair) • William Walker – (Chair-Elect) • Johnese Spisso – (Secretary) • David Lopez – (Treasurer) • Stephen McKernan – (Past Chair) • Alan Aviles • Betsey Bayless • Michael Belzer • Reginald Coopwood • Steven Gabbe • Arthur Gianelli • Michael Karpf • Jorge Orozco • Sheldon Retchin • Irene Thompson – (Ex Officio)	• Timothy Goldfarb • George Hernandez • Santiago Muñoz	• Bruce Siegel • Alan Burk • Linda Cummings • David Engler • Rhonda Gold • Carl Graziano • Shawn Gremminger • Jane Hooker • Xiaoyi Huang • Kristine Metter • Katherine Susman

Agenda Items	**Minutes**
Call to Order and Disclose Conflicts of Interest (Traylor)	• Call to order at 8:09 am • Acknowledgements: o Welcome Steven Gabbe to the board o New bylaws have been passed o Betsey Bayless to step down from Maricopa Integrated Health System in spring 2014 o Recognized the historical implications of the day: first day of the Affordable Care Act's health insurance marketplaces and a government shutdown • Request for conflicts of interest; none disclosed
Consent Agenda (Traylor)	• Approve new members o This year brought a net gain of six members, with eight joining and

	two leaving. Noted that the two losses were not due to membership o issues: Cooper Green is no longer offering inpatient services and Louisiana State University System devolved into private, nonprofit hospitals. • Approve June 2013 meeting minutes • Approve finance committee appointments *Traylor requested a motion to approve the consent agenda. Retchin made a motion and Karpf seconded. This was unanimously approved.*
President and CEO's Report (Siegel)	• In June, the association underwent a successful rebranding that has been very well received. The new brand reinforces the message of association members as essential to people and communities, and some audiences appear to have already adopted the "essential" brand as a new reference to the safety net. • Membership voted recently to approve new bylaws. • Two new interest groups have been launched in the past few months: one on 340B and one for foundation directors. Both groups hold bimonthly conference calls. • 2014 will feature focused programming on the new 1115 Medicaid waivers, soon to be operative in seven states. These waivers tie incentive payments to quality measures. America's Essential Hospitals will not participate in state-level waiver negotiations, but will meet with the Centers for Medicare & Medicaid Services (CMS) on a meta level about the importance and implications of these waivers; provide members with "waivers 101" training; and help members understand larger trends from state to state. This programming may include various reports and distance learning opportunities. • Currently engaged in contract negotiations with CMS (regarding the Essential Hospitals Engagement Network) and UHC, and both are going well. David Engler will meet with UHC's Tom Robertson and others later this fall to speak about future partnerships. • Siegel met with CMS Administrator Marilyn Tavenner at a roundtable for CEOs. Three main issues were discussed: disproportionate share hospital (DSH) funding (particularly Medicaid), evaluation & management (E&M) payments, and essential community provider status. • Siegel also met with new administrators at the Office of Management and Budget (OMB). This is an important relationship to develop and maintain, due to OMB's role in reviewing all waivers. • Siegel noted that the fall Legislative Event will continue as planned, but that the federal government shutdown likely will affect the event's schedule.
Treasurer's Report (Lopez)	• New finance committee comprises: Lopez (chair), Spisso, Gianelli, Coopwood, and Orozco. Siegel and Rhonda Gold provide staff support. • Review of the most recent financial projection: o The projected revenue of $8.14 million is $30,000 better than last projected (in June) and on target with budget. o Projected expenses of almost $7.13 million are 8 percent less than last

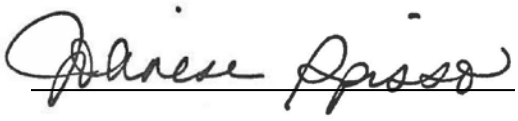
	projected (by $577,000) and budgeted (by $657,000), resulting in a $990,000 operating surplus (after unrealized gains of $148,000 and one-time rebranding cost of $175,000). o The surplus is primarily a result of salary and fringe line savings, external support to the Essential Hospitals Institute, conference expense savings, and lower projected rebranding fees. o The total projected net assets are almost $6.26 million, of which $250,000 is restricted to cover the association's upcoming office relocation. The association has close to one year of operating expenses in reserves. *Lopez made a motion to approve the treasurer's report and McKernan seconded. The motion was unanimously approved.* • The finance committee will meet in November to review the 2014 budget, which will then be presented to the board December 11. • Siegel addressed the office relocation, for which he has begun interviewing architects. The association plans to stay in the core downtown area of Washington. It is expected that the new location will have a higher rental rate and that this might be offset by a smaller square footage area.
Legislative and Policy Update (Gremminger and Huang)	• The 113th Congress has passed only 31 pieces of legislation, reflecting an acutely partisan climate. • President Obama requested a one-year delay in DSH cuts, which is a significant victory for the association and its members. • October 17 is the last day for Congress to raise the debt ceiling before defaulting on the nation's loans. • In July, the administration delayed employer mandates, which emboldened opponents in their efforts to repeal, defund, or delay the law. • The recent gun control bill contained language that would have included a delay in Medicaid DSH cuts, but the bill did not make it through the Senate. • The association has worked to include health care access and coverage in the debate on immigration reform. Immigrants now must wait 15 years between the time they apply for citizenship and when they may receive federally funded health care. It is unlikely Congress will pass legislation on this topic. • There is strong interest in repealing the sustainable growth rate (SGR). The House Energy and Commerce Committee approved legislation that would permanently repeal Medicare's flawed SGR and replace it with a new payment system. This bill does not include offsets to cover the cost of repealing the current SGR. • America's Essential Hospitals continues its focus on Medicaid DSH, calling for a three-year delay in cuts and federal review of key data, such as the amount of Medicaid allotment, uncompensated care, Medicaid losses, and marketplace losses, in assessing future reductions. • A final rule for carrying out ACA Medicaid DSH cuts has been issued. For Medicare DSH, a ruling in August reduced aggregate payments by

	about $550 million (smaller than $1 billion in the proposed rule). • The regulatory world is active right now, in part due to the start of health insurance marketplace operations October 1. There is concern about the ability of hospitals and other providers to contract with marketplace plans. While the ACA requires plans to contract with essential community providers, it only requires plans in federally facilitated marketplaces to contract with 20 percent of providers in any given category. The association is working with multiple parties to analyze how this impacts essential hospitals and other providers.
Keys to E & M Success (Gremminger)	• In November 2011, MedPAC recommended that Congress reduce outpatient payments for evaluation and management (E&M) services, which would disproportionately impact members, who would absorb 15 percent to 20 percent of these cuts. • By working with committees of jurisdiction, the association successfully argued that the policy change would undermine the ambulatory networks of essential hospitals. This resonated on a bipartisan basis and multiple policy solutions were created to mitigate the issue. • Although the change to E&M payments was not made, it could resurface in future budget discussions.
Policy Advisory Committee Report (Walker)	• The committee has been focusing on the concept of a federal designation in statute for essential hospitals. On September 19, the committee voted to pass certain criteria for this designation, and approved the criteria 13-1. • The board was briefed on the committee's activities and referred to the "Policy Advisory Committee Report" in the board book. • The board then discussed the report, asked questions, and voiced concerns. It was noted that the criteria outline a social policy and also identify targets for membership recruitment. Issues noted included an unintended and unavoidable bias against small hospitals and rural hospitals that serve large regions. With respect to the latter, it was noted that rural hospitals benefit from critical access designation, which set a precedent for the association's proposal. *Walker requested a motion to approve the criteria, including proxies as amended by the policy advisory committee. Lopez made a motion to approve and Karpf seconded. The motion was approved unanimously.*
Membership Committee Report (Lopez)	• There has been a net gain of six members in 2013. • With the support of a consultant, the association is considering a dues restructuring. • Many members belong to several organizations. So, America's Essential Hospitals must raise awareness of the value it provides members compared with other groups. • A dues restructuring may bring changes in membership numbers, so it is important to consider how growth will impact the association's mission. • One issue is that different organizations have different fiscal years; any changes should be sensitive to that, while not interrupting the association's revenue.

	• There will be three membership committee calls through March 2014. During these calls, the consultant will present a variety of membership/financial models, as well as potential barriers and risks. • In March 2014, the committee will make a recommendation to the board. There will then be nine months to communicate any changes to the membership for a 2015 implementation. Siegel will speak with many, if not all, members to ensure full understanding of and a smooth transition to the new dues structure.
Education Committee Report (Belzer)	• The committee met in person September 9. • The committee includes five new members: Craig Cathcart, Theodore Chan, Thomas Quatroche, Stephanie Thomas, and Joseph Woelkers. • 2014 objective is to apply an essential hospitals perspective to as many educational activities as possible, and link educational programming to the strategic plan. • Two focal points for the next year are population health and Section 1115 waivers. These topics will be reflected in webinars and annual conference programming. • The Fellows Program target class size remains 40 to 45. The accepted topic will be adaptive leadership. Applications for 2014 fellowships will 6open in early December. • While the association has planned an aggressive schedule of distance learning events in 2014, there is room for expansion. • The goal for VITAL2014 (the annual conference) is to increase participation, both by reaching deeper into attending organizations and engaging members who have not previously participated. Proposed tracks for this year include leadership, quality and safety, financing, and 1115 waivers. There will be pre-conference and post-conference workshops, with programming and speakers to be determined. Possible interest group sessions are being considered, including the potential launch of a medical leadership group. • The board discussed the role of disparities and equity of care as an educational topic to explore. This would be substantiated by collecting race, ethnicity, and language (REAL) data from providers through the EHEN.
Sponsorship and Corporate Relations (Metter)	• This year, America's Essential Hospitals collected $237,000 in sponsorship fees (mostly from the annual conference). • This is an important revenue stream, particularly for covering the expense of the conference (registration fees do not cover the total cost). • The board then reviewed a list of sponsors from the past two years. • Request made that board members engage with and thank current sponsors, and share leads for potential new sponsors.
Essential Hospitals Institute Update (Engler and Cummings)	• The Transformation Center currently has two aims: building integrated delivery systems and developing industry leaders in access and quality of care. • A decision is expected soon on a third year of federal funding for the EHEN. • The EHEN comprises 22 hospitals nationwide, and is the only safety net-

	focused HEN. It also uses a unique process for counting harm events. Over the past 18 months, the EHEN has seen a reduction of 1,674 harm events, which is a great quality and policy success. Another calculation concluded that EHEN has saved roughly $16.69 million , which is a 2:1 ratio on the return of a $7.84 million investment. • This network follows a two-prong approach to analysis: focused Plan, Do, Study, Act (PDSA) cycles with members; and a leadership webinar series. Regarding the probability of getting funding for a third year, all technical requirements have been met, including deliverables, so chances are strong. With new funding, the EHEN would explore REAL data and other issues related to disparities. • The Institute is working on two other major projects: o A project funded by the Patient Centered Outcomes Research Institute (PCORI) that focuses on reducing disparities in care and includes a series of site visits. This project concludes in December 2013. o A project to build safety net capacity and collaboration, particularly under new demands of health care reform. The association is conducting this Kaiser Permanente-funded project in partnership with the National Association of Community Health Centers (NACHC) and The George Washington University School of Public Health and Health Services (SPHHS). The three-year project has $1.8 million in funding (shared with the two partners). This is the first formal partnership between America's Essential Hospitals and NACHC. • Proposed 2014 projects will focus on population health and section 1115 Medicaid waivers. Objectives include defining the relevancy of these issues to essential hospitals; disseminating leading practices from members; measuring outcomes; and supporting education, policy, and advocacy. The proposed partner for one initiative is AcademyHealth.
New Business	None.
Executive Session	The board went into executive session and the meeting was adjourned at 11:45 am.

Submitted by:



Johnese M. Spisso, RN, MPA
S*ecretary*

AMERICA'S ESSENTIAL HOSPITALS

DATE March 24, 2014
TO Board of Directors
FROM Kristine Metter, Vice President for Member Services
RE New Member Applications MEMORANDUM

Five hospitals have applied for membership with America's Essential Hospitals:

- Bon Secours Baltimore Health System, Baltimore
- Erlanger Health System, Chattanooga, Tennessee
- Liberty Health/Jersey City Medical Center, Jersey City, New Jersey
- Oklahoma State University Medical Center, Tulsa, Oklahoma
- United Medical Center, Washington, DC

Bon Secours Baltimore Health System
Sam Ross, MD, CEO

In 1919, the Sisters of Bon Secours opened their first Bon Secours Hospital in the United States on West Baltimore Street, in Baltimore. Today Bon Secours Hospital has 125 acute care beds and its approach to community health reaches beyond the traditional model of health care. Patients and communities are cared for holistically with traditional acute-care services and an array of ambulatory and community services.

Bon Secours Statistics

Beds	115
Employees	812
Discharges (Medicare)	32.7
Discharges (Medicaid)	27.0
Outpatient visits	119,805
Total Admissions	6,521
Births	-

*Source: American Hospital Association (AHA) 2012 utilization statistics

Erlanger Health System
Kevin Spiegel, President and CEO

Erlanger is a non-profit, academic teaching center affiliated with the University of Tennessee College of Medicine. Erlanger is also a level I trauma center for adults and the only provider of tertiary care services for the citizens of a four-state region, encompassing southeast Tennessee, north Georgia, north Alabama, and western North Carolina. With a history that dates back more than a century, Erlanger is recognized as one of the nation's finest public hospitals.

Erlanger Health System Statistics

Beds	788
Employees	3,389
Discharges (Medicare)	23.7%
Discharges (Medicaid)	26.2%
Outpatient visits	258,688
Total Admissions	28,773
Births	5,345

*Source: AHA 2012 utilization statistics

Liberty Health/Jersey City Medical Center
Joseph Scott, MD, President and CEO

Founded in 1882, Jersey City Medical Center was one of the first medical centers in the United States and the first in New Jersey. In 1988, the medical center became a private, non-profit organization. In 1994, the State of New Jersey designated the medical center as a regional trauma center, and in the late 1990s it was approved as a core teaching affiliate of Mount Sinai School of Medicine. The hospital also has a teaching affiliation with the New York College of Osteopathic Medicine.

Liberty Health Statistics

Beds	316
Employees	1,959
Discharges (Medicare)	29.4%
Discharges (Medicaid)	30.0%
Outpatient visits	145,251
Total Admissions	15,608
Births	1,808

*Source: AHA 2012 utilization statistics

Oklahoma State University Medical Center
Diane Rafferty, MHA, CEO

OSU Medical Center (OSUMC) is the nation's largest osteopathic teaching facility. There are 11 residency programs and nine fellowship programs at OSUMC that train more than 150 residents in primary care and subspecialties annually. Together, OSU Center for Health Sciences and the medical center have trained more than 2,000 physicians, many of which actively practice in Oklahoma. In 2009, ownership of OSUMC was transferred to a municipal-owned trust.

OSUMC Statistics

Beds	249
Employees	1,183
Discharges (Medicare)	37.3%
Discharges (Medicaid)	29.0%
Outpatient visits	71,457
Total Admissions	6,584
Births	509

*Source: AHA 2012 utilization statistics

United Medical Center
David Small, Interim CEO

Founded in 1966 as Greater Southeast Community Hospital, UMC is today a non-profit, full-service community hospital serving Southeast DC and nearby Maryland communities. It is the only hospital serving residents east of the Anacostia River.

United Medical Center Statistics

Beds	354
Employees	654
Discharges (Medicare)	31.5%
Discharges (Medicaid)	54.2%
Outpatient visits	218,394
Total Admissions	5,862
Births	558

*Source: AHA 2012 utilization statistics

AMERICA'S ESSENTIAL HOSPITALS

DATE March 24, 2014
TO Board of Directors
FROM Caroline Jacobs, Chair, Institute Nominating Committee
RE 2014 Institute Board Elections MEMORANDUM

The Essential Hospitals Institute nominating committee met February 21 to consider candidates for election to the Institute board. By our new bylaws, the America's Essential Hospitals board elects directors to the Institute board. The nominating committee recommends the following candidates for election.

Officers
Chair-elect/secretary: Anna Roth, RN, MS, MPH, CEO, Contra Costa Regional Medical Center

Treasurer: Leon Haley, MD, MHSA, Executive Associate Dean, Clinical Services, and Chief Medical Officer, Grady Health System

New Directors

Delvecchio Finley, MPP, CEO, Harbor-UCLA Medical Center
Finley was appointed as CEO of Harbor-UCLA Medical Center October 1, 2011. He has extensive experience in health care, beginning as a division administrator at the University of California, San Francisco (UCSF), where he was responsible for administrative and financial oversight of several medical subspecialties. Previously, he held several executive positions in other public hospitals, including associate administrator at San Francisco General Hospital and Trauma Center and interim chief operating officer at Laguna Honda Hospital and Rehabilitation Center. Most recently, Finley was vice president of operations at California Pacific Medical Center (CPMC).

Finley holds a bachelor's degree in chemistry from Emory University. He received his master of public policy degree at Duke University, where he also attended graduate certification in health policy, law, and management. Finley is board certified in healthcare management and he is a Fellow in the American College of Healthcare Executives (ACHE). He has held several leadership roles in local and national professional organizations. He completed a three-year stint as ACHE regent for the California-Northern and Central region. Finley is past-president of the California Association of Healthcare Leaders (CAHL) and past-president of the Northern California chapter of the National Association of Health Services Executives (NAHSE).

Finley is also a graduate of the 2007-08 class of Leadership San Francisco and a 2008 Fellow of America's Essential Hospitals. He frequently guest lectures at colleges and universities throughout Northern California and has been published in major health care publications, including *Healthcare Executive* and the *Journal of Healthcare Management*.

Finley played an active role in the local community. He served as a Big Brother in Big Brothers/Big Sisters Organization. He was also a board member for Operation Access (an organization that connects medical volunteers, hospitals, and uninsured patients needing minor operations), and Out of Site Center for Arts Education. Finley is happily married to attorney and entrepreneur Kelly Patrice Finley.

Erica Murray, President and CEO, California Association of Public Hospitals and Health Systems (CAPH)

Erica Murray serves as president and CEO for CAPH, a statewide trade association with a mission to advance public policies that support the essential role of hospitals that provide access to care for low-income and uninsured patients. Prior to her appointment in 2013, Murray was senior vice president and, in that capacity, was responsible for leading the organization's policy and government relations efforts.

Murray has worked at CAPH since 2005, with a focus on policies to support and strengthen public hospital systems' successful delivery system improvements, many of which have been fostered by CAPH's affiliate, the California Health Care Safety Net Institute (SNI). These improvements include chronic disease management, language access services, and outpatient service delivery efficiencies. Prior to joining CAPH/SNI, Murray served as health policy legislative assistant for former U.S. Sen. John Edwards (D-NC). From 1997 to 1999, she served as a consultant to the U.S. Department of Health and Human Services, where she helped launch the AIDS Drug Assistance Program, a $1.4 billion federal program that provides access to HIV/AIDS medications for uninsured, low-income individuals.

Murray holds a masters of public policy and administration from Columbia University, and received a bachelor's degree from McGill University, in Montreal, Quebec.

Re-elected Directors

Susan Moffatt-Bruce, MD, PhD, Chief Quality and Patient Safety Officer, The Ohio State University Wexner Medical Center

Christine Neuhoff, JD, System Vice President and General Counsel, St. Luke's Health System

2014-2015 Institute Board Roster

CHAIR
Caroline Jacobs, MPH, MSEd
Senior Vice President, Safety & Human Development
New York Health and Hospitals Corporation

CHAIR-ELECT/SECRETARY
Anna Roth, RN, MS, MPH
CEO
Contra Costa Regional Medical Center

PAST CHAIR
Cliff Wang, MD
Hospitalist, Division of Medicine
Santa Clara Valley Medical Center

TREASURER
Leon Haley, MD, MHSA
Executive Associate Dean, Clinical Services, and Chief Medical Officer
Grady Health System

MEMBER DIRECTORS

John Bluford, III, MBA (2013-2015)
President and CEO
Truman Medical Centers

Delvecchio Finley, MPP (2014-2016)
CEO
Harbor-UCLA Medical Center

Susan Moffat-Bruce, MD, PhD (2014-2016)
Chief Quality and Patient Safety Officer
The Ohio State University Wexner Medical Center

Christine Neuhoff, JD (2014-2016)
System Vice President and General Counsel
St. Luke's Health System

Rueven Pasternak, MD, MPH, MBA (2013-2015)
CEO
Stony Brook University Hospital

OUTSIDE DIRECTORS

Don Goldmann, MD (2013-2015)
Chief Medical and Scientific Officer
Institute for Healthcare Improvement

Erica Murray (2014-2016)
President and CEO
California Association of Public Hospitals and Health Systems

Ann Scott Blouin, PhD, RN (2014-2015)
Executive Vice President of Customer Relations
The Joint Commission

Alan Weil, JD, MPP (2013-2015)
Executive Director
National Academy for State Health Policy

Winston Wong, MD, MS (2013-2015)
Medical Director, Disparities Improvement and Quality Initiatives
Kaiser Foundation Health Plan

Julie Cerese, RN, MSN, (ExOfficio)
Senior Vice President, Performance Improvement
UHC

Board Action: Elect candidates to the Institute board of directors as outlined above.

AMERICA'S ESSENTIAL HOSPITALS

DATE	March 24, 2014	
TO	Board of Directors	
FROM	William Walker, Chair, Association Nominating Committee	
RE	Nominating Committee Report	MEMORANDUM

America's Essential Hospitals nominating committee met February 3 to consider the slate for the annual board elections. The committee also considered candidates for board vacancies created by changes in employment for two current directors.

Slate for Member Election

The slate for member election of the association board of directors includes three new directors and four re-elected directors. The member election will be completed in April.

For re-election to a 2014-2016 term

- Michael B. Belzer, MD
- Timothy M. Goldfarb
- George B. Hernandez, Jr., JD
- Sheldon Retchin, MD, MS, MSP

New for a 2014-2016 term

- John Haupert
  President and CEO
  Grady Health System

- Donna Sollenberger, MA
  Executive Vice President and CEO, UTMB Health System
  The University of Texas Medical Branch

- Roxane Townsend, MD
  Vice Chancellor for Clinical Programs and CEO
  University of Arkansas for Medical Sciences

Additionally, the 2014-2015 officers are as below.

CHAIR
William B. Walker, MD
Director and Health Officer
Contra Costa Health Services

CHAIR ELECT
Johnese M. Spisso, MPA, RN
Chief Health System Officer, UW Medicine
UW Medicine

PAST CHAIR
Thomas P. Traylor, MBA
Vice President, Federal, State and Local Programs
Boston Medical Center

SECRETARY
David S. Lopez
President and CEO
Harris Health System

TREASURER
Reginald W. Coopwood, MD
President and CEO
Regional Medical Center at Memphis (The MED)

Current Vacancies

Two director positions are currently vacant with unexpired terms. These are created by the resignations of Art Gianelli and Alan Aviles, who have both changed employment. Under our bylaws, such vacancies are filled by a board majority vote. The nominating committee recommends appointment of Wright Lassiter, CEO, Alameda Health System; and Ram Raju, incoming CEO, New York Health and Hospitals Corporation, to fill those unexpired terms. Both have been engaged with the association and can bring leadership and thoughtfulness to the board's deliberations. Both would be eligible for election to full terms in 2015.

Wright Lassiter, III
Wright L. Lassiter, III has led Alameda Health System (AHS) since 2005. Nationally known as a successful turnaround leader, Mr. Lassiter has created a culture of excellence, while maintaining a fervent focus on the system's safety net mission. He has been credited with significantly expanding access to key services, aggressively improving operating efficiency, and raising the bar for patient experience at AHS.

In April, Mr. Lassiter was named one of *Modern Healthcare* magazine's Top 25 Minority Executives in U.S. Healthcare for 2012. The prestigious national award

recognizes minority health care executives for success within an organization, the ability to effect change in the industry, a willingness to share expertise, and service as a mentor or role model to other minority leaders. Additionally, Mr. Lassiter was featured in the December 2011 cover story "The HealthLeaders 20" in *HealthLeaders* magazine. Also in December, Mr. Lassiter appeared in a panel discussion on "Achieving Health Care Greatness" at the Second World Health Care Congress Middle East, in Dubai.

AHS is a comprehensive public health authority comprising three hospitals and three freestanding wellness centers. AHS carries a total bed license of 475, and its acute care facilities include Highland Hospital, a 236-bed trauma and teaching facility and location for the award-winning documentary "The Waiting Room." Additional acute locations are John George Psychiatric Pavilion, an 80-bed acute mental health facility, and Fairmont Hospital, a 159-bed skilled nursing and acute rehabilitation hospital. The system also includes nearly three dozen primary care and specialty clinics on the Highland campus.

Prior to AHS, Mr. Lassiter was senior vice president, operations, for JPS Health Network, in Fort Worth, Texas. In that role, he oversaw operations of Tarrant County's public health system and expanded ambulatory care and specialty health services throughout the county. Prior to his tenure in Fort Worth, Mr. Lassiter spent more than 10 years at Methodist Health System, in Dallas. He served in several roles there, culminating as vice president, operations.

Mr. Lassiter holds a master's degree in health care administration from Indiana University. A passionate community leader, Mr. Lassiter currently serves as board chair for the YMCA of the East Bay, the Alameda Alliance for Health, and the California Association of Public Hospitals and Health Systems.

Ramanathan (Ram) Raju, MD, MBA, FACS, FACHE

Dr. Ram Raju has been appointed by New York City Mayor Bill de Blasio to be president of the New York City Health and Hospitals Corporation (HHC), effective spring 2014. Dr. Raju most recently served as the CEO of the Cook County Health & Hospitals System, in Chicago, since 2011. CCHHS is the third largest public health system in the country. Prior to CCHHS, Dr. Raju served as HHC's executive vice president for medical and professional affairs in New York. He also served as chief medical officer of Coney Island Hospital and assumed the additional responsibilities of chief operating officer in 2005. Dr. Raju trained in India, England, and the United States, and has a long and distinguished career as a board-certified surgeon and has held faculty positions at a variety of institutions.

2014-2015 Board of Directors

CHAIR
William B. Walker, MD
Director and Health Officer
Contra Costa Health Services

CHAIR ELECT
Johnese M. Spisso, MPA, RN
Chief Health System Officer, UW Medicine
UW Medicine

PAST CHAIR
Thomas P. Traylor, MBA
Vice President, Federal, State and Local Programs
Boston Medical Center

SECRETARY
David S. Lopez
President and CEO
Harris Health System

TREASURER
Reginald W. Coopwood, MD
President and CEO
Regional Medical Center at Memphis (The MED)

AT-LARGE DIRECTORS

Michael B. Belzer, MD (2014-2016)
Medical Director and Chief Medical Officer
Hennepin County Medical Center

Steven G. Gabbe, MD (2013-2015)
Senior Vice President for Health Sciences, CEO
The Ohio State University Wexner Medical Center

Timothy M. Goldfarb (2014-2016)
CEO
UF Shands HealthCare

John Haupert (2014-2016)
President and CEO
Grady Health System

George B. Hernandez, Jr., JD (2014-2016)
President and CEO
University Health System

Michael Karpf, MD (2013-2015)
Executive Vice President for Health Affairs
UK HealthCare

Wright Lassiter, III (2014-2015)
CEO
Alameda Health System

Santiago Muñoz (2013-2015)
Chief Strategy Officer
UCLA Health System

Ramanathan Raju, MD, MBA (2014-2015)
CEO
New York City Health and Hospitals Corporation

Sheldon Retchin, MD, MS, MSP (2014-2016)
Vice President, Health Sciences and CEO
Virginia Commonwealth University Health System

Donna Sollenberger, MA (2014-2016)
Executive Vice President and CEO, UTMB Health System
The University of Texas Medical Branch

Roxane Townsend, MD (2014-2016)
Vice Chancellor for Clinical Programs and CEO
University of Arkansas for Medical Sciences

EX OFFICIO
Irene M. Thompson
President and CEO
UHC

Board Action: Elect Wright Lassiter and Ram Raju to fill the director positions currently vacant and with unexpired terms.

AMERICA'S ESSENTIAL HOSPITALS

DATE March 24, 2014
TO Board of Directors
FROM David Lopez, Membership Committee Chair
RE Dues Restructuring Proposal

MEMORANDUM

Introduction

The membership committee of America's Essential Hospitals is considering a dues restructuring as part of its 2014 work. We are grateful for the time the committee has already put into this issue, and many of the committee's ideas and discussions are reflected below. Our objectives are that the restructuring occurs equitably and fairly and fosters continued association growth and fiscal stability.

Overview

America's Essential Hospitals currently employs a flat membership dues structure for almost all its members, regardless of hospital size. This can lead to dues payments substantially out of proportion to hospital size. A few members pay higher dues as a result of historic arrangements (with two members annually making the equivalent of four base dues payments). There are no membership pricing guidelines currently, and this has made it difficult to decide how much to charge new members—some of whom may be quite large or quite small. This lack of structure contributes to increasing dues inequities and inconsistency.

We also recognize there is strength in numbers. With members in 32 states and the District of Columbia, we know the value of our collective voice and aim to create a membership model that attracts organizations from all 50 states, strengthening our ability to represent hospitals serving the most vulnerable. Any dues model also needs to reflect the prospect of some larger, multistate systems joining the association and ensuring these systems pay their fair share.

Staff from America's Essential Hospitals worked with Avenue M Group, LLC, to plan and identify the best way to restructure dues. We examined numerous membership dues models, including the option of maintaining our current model. The process

included an environmental assessment, member survey, a study of available hospital data, and modeling of multiple dues options on the individual member level.

The values guiding this work included these:

- Extreme swings in dues should be dampened as much as possible.
- Dues should reflect the size of the member's enterprise.
- Any pricing structure should make it easier for small hospitals to join.
- Dues changes should be minimized for the average size member.
- Pricing should be designed to encourage systems to have multiple hospitals join the association.
- Dues amounts need to be reasonable in comparison with our competitive landscape.

These values led to the rejection of several models. For example, one considered option would have charged every member a fixed percentage of total expenses. Under that scenario, our smallest members would have seen dues decrease by 96 percent, to $2,217, while the very largest members would experience an increase of more than 100 percent, to $466,569. We rejected this model due to the huge swings in individual dues that would result.

Proposed Dues Structure

Staff recommends a dues restructure based on this methodology:

- Dues are based on member expenses, as the committee recommended in earlier deliberations.
- To dampen swings and simplify pricing, dues limits are set at a minimum of $25,000 and a maximum of $500,000 (no current member would pay more than $320,000).
- Members are grouped into nine tiers based on hospital expenses and looking at natural breaks in the data. Dues are set for each tier (see Figure 1 below).
- Hospitals in dues tiers $65,000 and lower would be immediately placed into their new tiers in 2015 and then incur the 5 percent standard increase annually thereafter, as is our current practice. This group represents the majority of our members.
- Hospitals at the $85,000 tier and higher will be phased in over two years to their tiered structure to soften the transition, reaching full implementation in 2016 and then incurring the 5 percent standard increase in subsequent years.
- To take a conservative approach in analyzing the potential financial impact of this change, we assumed the proposed tiered structure of membership dues would lead to the **net** loss of four members (two from the $85,000 tier and two from the $100,000 tier). The proposed tiered structure and resulting financial figures also do not assume any new members.

This proposed dues restructure is reflected in Figure 1. **Under this scenario, 57 percent of current members will see a net decrease or a modest net increase in dues.**

Figure 1

Hospital Expenses (not including bad debt)	Proposed Dues Rates	# of current members in tier
<$100M	$25,000	3
$100M-<$250M	$45,000	8
$250M-<$750M	$65,000	34
$750M-<$1.5B	$85,000	21
$1.5B-<$2B	$100,000	8
$2B-<$3B	$165,000	2
$3B-<$5B	$235,000	1
$5B-<$10B	$320,000	2
$10B and greater	$500,000	0

Financial Impact

Figure 2 shows the impact of this scenario on association dues revenue.

Figure 2

Year	Revenue under existing model*	Revenue under proposed model (with percent net change over existing)**
2015	$8,401,958	$8,627,144 (2.7%)
2016	$8,730,500	$9,315,127 (6.7%)
2017	$9,073,639	$9,687,497 (6.7%)
2018	$9,432,067	$10,076,618 (6.7%)
2019	$9,806,511	$10,483,289 (6.7%)
2020	$10,197,734	$10,908,352 (6.7%)

**revenue based on:*

- *current members with the 5 percent standard increase per year*
- *UHC dues with the contractual 2 percent increase per year*

***revenue based on:*

- *current members with the 5 percent standard increase per year, less four lost members (two from the $85,000 tier and two from the $100,000 tier)*
- *UHC dues with the contractual 2 percent increase per year*

Comparative Market Data

Figure 3 shows comparative pricing data for several members of America's Essential Hospitals. Based on these figures, we believe our pricing would remain competitive (and may indeed be currently too low).

Figure 3

Hospital	State Association Dues	AHA Dues	Proposed America's Essential Hospitals Dues
Hospital A	N/A	$50,000	$65,000
Hospital B	$116,000	$77,702	$65,000
Hospital C	$51,228	$61,128	$65,000
Hospital D	$180,000	N/A	$65,000
Hospital E	N/A	$85,842	$85,000
Hospital F	$189,436	N/A	$85,000
Hospital G	$244,085	$103,531	$85,000
Hospital H	$239,485	$142,795	$85,000
Hospital I	$246,798	$153,228	$100,000
Hospital J	$330,000	$109,710	$320,000

Other Membership Categories

Note that the proposed dues structure applies only to "full" members: public and nonprofit, acute care hospitals and multi-hospital systems. We currently have three members that would not qualify for the full member category going forward (including two state associations). The association's bylaws allow for "associate" and "affiliate" members, as well. A proposal for both the associate and affiliate member categories will be brought to the membership committee and board later this year.

Next Steps

In April/May, Avenue M Group will conduct a limited market test of approximately 10 members to solicit feedback on the proposed dues structure. A finalized structure will be brought back to the board for consideration and action during its June meeting. If there is a decision to change the dues structure, staff will communicate the new pricing to each member in July. The association will send 2015 dues invoices in early November.

AMERICA'S ESSENTIAL HOSPITALS

DATE March 24, 2014
TO Board of Directors
FROM Michael Belzer, Education Committee Co-chair
RE Education Committee Report MEMORANDUM

On behalf of the education committee, I am pleased to share the following update on 2014 educational programming.

1115 Delivery System Reform Incentive Payment (DSRIP) Waivers

Staff has organized a comprehensive educational work plan focusing on section 1115 waivers to include a webinar series, sessions at the annual conference, two written products, and possible one-day workshop.

2014 Webinar Series	VITAL2014 Breakout Sessions
December 17, 2013 "Medicaid Payments to Incentivize Delivery System Reform" Attendance: 64 Avg. Satisfaction Score: 4.47 (on a 5-point scale)	June 26, 2014 10:45 am - Noon "Learn from Experience: Texas DSRIP Hospitals Share"
February 11, 2014 "DSRIP Waiver Implementation: One Hospital's Experience" Featured Member: Santa Clara Valley Medical Center in California Attendance: 76 Avg. Satisfaction Score: 4.2 (on 5-point scale)	June 26, 2014 2:25 – 2:45 pm "Recent Trends in DSRIP Waivers"
April 24, 2014 Featured Member: Boston Medical Center	June 26, 2014 3:00 – 3:30 pm "State Medicaid Waivers: A Path to Clinical Improvement"
July 23, 2014 Featured Member: UT Health Northeast, Texas	

- **Keynote Speakers**
  Confirmed keynote speakers include **Stephen Johnson,** bestselling author, *Where Good Ideas Come From* and *Future Perfect;* and **Rebecca Onie,** co-founder and CEO, Health Leads

- **Post-Conference Workshops**

Sustaining the Gains: How to Maintain Quality Improvement

Current estimates show that as many as 70 percent of improvement projects fail to be sustained. Understanding the 10 factors that impact sustainability is critical to succeeding in today's changing environment.

Lynne Maher, PhD, director of innovation at Ko Awatea and associate honorary professor of nursing at the University of Auckland, will teach participants how to evaluate their organizational improvement projects and identify actions that will help increase sustainability. Maher will base her discussion on a sustainability model built during her tenure at the National Health Service.

Audience: Clinical leadership

Leading Through the Second Curve: Managing Transformation

Health care leaders are increasingly supporting the push to transition our health care system into one that values high-quality, comprehensive care over volume-driven, episodic care. But they struggle with making this transition.

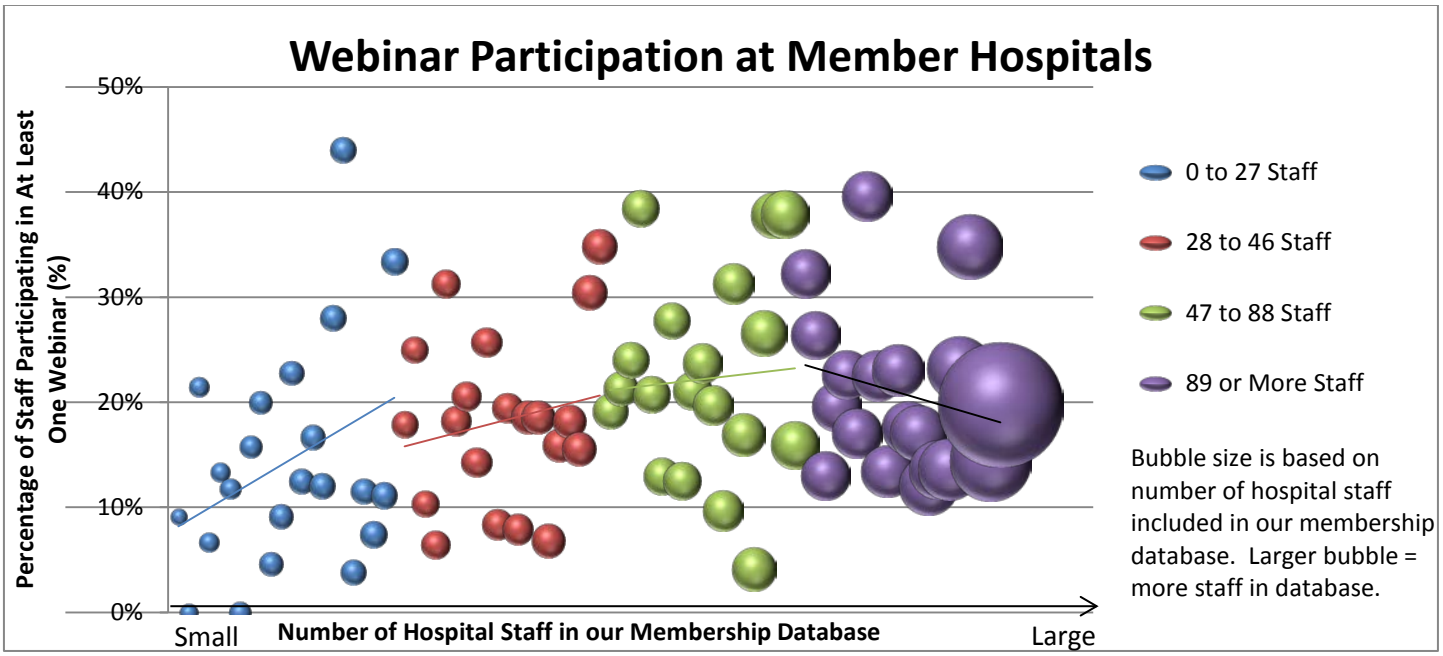
James B. Conway, MS, adjunct lecturer, Department of Health Policy and Management at the Harvard School of Public Health, will review core content on leading and managing change, specifically focusing on adaptive change and navigating through the emerging "second curve" of health care. Driven by the audience, content will include issues on which attendees are specifically focused, including active engagement with the patient, family, public, and community.

Previously, Conway served as senior vice president, Institute for Healthcare Improvement; and executive vice president and chief operating officer, Dana Farber Cancer Institute

Audience: Executive and clinical leadership

2013 Webinar Participation Analysis

In 2013, America's Essential Hospitals and Essential Hospitals Institute conducted 56 distance learning programs (webinars). Of the more than 5,000 people in our database who work for a member hospital or health system, 20 percent participated in at least one webinar in 2013.



Methodology:
A bubble chart helps visually identify trends in data. For this model, the member hospitals were sorted based on their size, from smallest to largest number of staff in our membership database. Then, each hospital was assigned a numerical ID (e.g., 1, 2, 3, etc.) based on size—values ranged from 1 to 81. Quartile measurements on staff size were then used to create four groups of hospital sizes. A bubble chart was created using the assigned numerical value for the *x*-axis value and the percentage of staff participating in at least one webinar on the *y* axis. Bubble size was determined using the actual number of staff at each hospital, with small bubbles representing smaller hospital staff size and larger ones representing hospitals with more staff.

Interpretation of Results:

- Groups 1, 2 and 3: For each of these groups, as the number of staff in the membership database increases, so, too, does the webinar participation. However, as noted by the trend lines, the trend levels off as the number of staff increases.
- Group 4: While participation in the members with the largest number of staff in the database is on par with the other groups, the trend seen in groups 1 to 3 reverses, with participation dropping off as the hospital staff size gets larger.

2014-2015 Fellows Program

Session I	Session II	Session III
June 23-27, 2014 San Antonio	October 8-10, 2014 Long Beach, California	March 18-20, 2015 Washington, DC
Adaptive Leadership: Mobilizing for Change	Adaptive Leadership: Leading at the Speed of Trust	Your Essential Hospital Leadership Legacy
Session Objective: Participants will strengthen the leadership skills needed to mobilize their organization to adapt and thrive in challenging environments.	Session Objective: Participants will gain a heightened sense of self-awareness and understanding regarding diversity issues of self and others.	Session Objective: Participants will gain important communications strategies to formally advocate on behalf of essential hospitals, apply leadership lessons learned through work on projects, and identify techniques for increasing resilience to stress.

About Cambridge Leadership Associates (CLA)
CLA is an international leadership development practice and the home of Adaptive Leadership™.

Adaptive Leadership emerged from 30-plus years of research at Harvard University by Dr. Ron Heifetz and Marty Linsky, defining the frontier of leadership training and development. Adaptive Leadership provides the framework, skills, and tools for responding to today's unrelenting, adaptive pressures of complexity, uncertainty, and constant change.

CLA generates rapid and measurable impact on organizational agility and leadership effectiveness. Working with companies, government agencies, non-profits, and individuals, CLA is committed to helping them identify their most significant challenges, generate new solutions, and exercise the leadership required to bring them to scale.

Today, CLA comprises a team of experienced consultants working around the globe and skilled in the practical application of Adaptive Leadership.

AMERICA'S ESSENTIAL HOSPITALS

DATE March 24, 2014
TO Board of Directors
FROM William B. Walker, MD, Chair, Policy Advisory Committee
RE Policy Advisory Committee Update

MEMORANDUM

On behalf of the policy advisory committee (PAC), I provide you with this update of the committee's activities. In the first half of 2014, the committee will examine alternative payment models used and considered in state Medicaid programs and develop principles the association and its members can use in educating and engaging state and federal policymakers. A description of the scope of this work is outlined below. A list of PAC members is included in Appendix A.

Over the next three months, the committee will examine existing Medicaid alternative payment models and explore other payment models that may be employed in the future. Medicaid alternative payment models vary widely in their design, often building on an individual state's existing payment framework and delivery pathway. Alternative Medicaid payment models include ideas such as patient-centered medical homes, episodes of care, bundled payments, accountable care organizations (ACOs), global budgets, and dual-eligible integration models. These alternative payment models all hold the promise to fundamentally change the way providers are paid for delivering health care services to Medicaid patients.

Interest on the part of states to implement alternative payment models is growing rapidly, and their approaches have varied. Minnesota was an early leader, passing a state law in 2008 to improve affordability, expand coverage, and improve the overall health of state residents, and following up with a later law that mandated the testing of alternative delivery systems, including ACOs. In 2012, Arkansas began testing the use of a shared savings model based on episodes of care to try to drive down the costs of care while improving quality. Massachusetts has firmly woven payment system transformation into its delivery system transformation waiver, and hospitals there are undertaking major projects to align with physicians to form ACOs and integrated care organizations, among other efforts. We believe that as interest in Medicaid waivers continues to grow, and as existing waivers come up for renewal, more states may look to include alternative payment approaches in their efforts.

The PAC will examine these recent developments across the states and develop a set of principles to which proposals for Medicaid alternative payment models should adhere. The PAC will bring these principles to the board for its review and approval at the June meeting. Following that meeting, America's Essential Hospitals will use the principles in member educational materials through our Medicaid waiver education efforts.

Appendix A - List of Policy Advisory Committee Members, Spring 2014

William B. Walker, MD - Chair
Director and Health Officer
Contra Costa Health Services

Kirk Calhoun, MD
President and CEO
UT Northeast

Jeff Feasel
President and CEO
Halifax Health

Steven G. Gabbe, MD
Senior Vice President for Health Sciences, CEO
The Ohio State University Wexner Medical Center

John M. Haupert
CEO
Grady Health System

Wright L. Lassiter, III
CEO
Alameda Health System

David Pate, MD, JD
President and CEO
St. Luke's Health System

Sheldon Retchin, MD, MSPH
Vice President, Health Sciences, and CEO
VCU Health System

Nancy Schlichting
CEO
Henry Ford Health System

Michael R. Waldrum, MD, MS, MBA
UAHN President and CEO
The University of Arizona Health Network

Patrick Wardell
President and CEO
Cambridge Health Alliance

AMERICA'S ESSENTIAL HOSPITALS

DATE March 24, 2014
TO Board of Directors
FROM Beth Feldpush, DrPH, Senior Vice President, Advocacy & Policy
RE Advocacy and Policy Update

MEMORANDUM

This memo outlines advocacy and policy activities of America's Essential Hospitals since the last in-person meeting of the board of directors, in October, and details our advocacy agenda and expectations for 2014.

Landmark Victory Delaying Medicaid DSH Cuts

Despite the continuation of political gridlock in the 113th Congress, movement has been made on several fronts since the board last met. Most important, in a victory for essential hospitals, Congress voted to **eliminate Medicaid disproportionate share hospital (DSH) payment cuts in fiscal year (FY) 2014 and to delay the FY 2015 Medicaid DSH cuts** when it passed a joint budget resolution at the end of 2013. Stopping immediate Medicaid DSH cuts had been a top priority for America's Essential Hospitals the past several years. The delay of the Medicaid DSH cuts marks the most significant legislative victory for the hospital field in 2013, and we are proud to have led this effort. Specifically, the budget legislation eliminated completely the FY 2014 Medicaid DSH cuts and delayed the 2015 cuts by a year, adding them to the existing 2016 cuts.

As a result, essential hospitals have a temporary reprieve from these damaging cuts. However, we are already beginning to plan the next wave of our advocacy efforts on Medicaid DSH. To that end, we have another effort in play that could assist with our advocacy on the DSH issue. Legislation the Senate Finance Committee passed in December 2013 to repeal and replace Medicare's sustainable growth rate (SGR) included a provision requiring the health and human services (HHS) secretary to issue annual reports regarding the future need for Medicaid DSH. The reports—which would begin in 2015—would include information regarding levels of uncompensated care in each state, uninsurance by state, and Medicaid losses by hospital. If enacted, these reports will help Medicaid DSH supporters make the case for further mitigating DSH cuts set to begin in 2016.

Continued Progress on a Permanent Repeal of the SGR

In February, House and Senate lawmakers introduced a consensus bill to repeal Medicare's flawed SGR formula for physician payments and replace it with a more stable payment system. This bill merged the bills passed last year in the Senate Finance, House Ways and Means, and House Energy and Commerce committees and represents groundbreaking movement toward permanently changing the way Medicare pays physicians. However, at the time the consensus bill was introduced, there was no agreement on what other provisions might also be included in the legislation, nor was there consensus on how to pay for the legislation, the cost of which the Congressional Budget Office estimates to be $138 billion.

The current, temporary patch for the SGR runs out March 31. That means that as of April 1, unless Congress takes further action, physicians will see large cuts to their Medicare payment rates. It is unlikely that, by the end of March, Congress will agree on what to include in the final legislative package and how to pay for it. Therefore, the most likely scenario now is that a further temporary patch will be put in place, likely through the end of 2014, to allow the committees to continue their work.

America's Essential Hospitals has met with key staff on each of the three committees of jurisdiction to urge them to include the DSH report language in the consensus legislation, as well as any short-term patches that go forward. Given the fact that the Medicaid DSH cuts now go into effect in October 2015, we believe Congress must act now to direct the HHS secretary to study DSH so that the critical information identified by such reports will be available in advance of the cuts.

President's FY 2015 Budget Request

On March 4, the Obama administration released its FY 2015 budget request to Congress. The $3.9 trillion budget projects a $564 billion deficit for the year, which is a 13 percent decrease from the previous fiscal year. Although Congress likely won't adopt the president's budget, there are several provisions in it that are of interest to essential hospitals. In total, the budget request proposes more than $400 billion in Medicare savings over 10 years, more than $350 billion of which would come from reductions to provider payments. Of particular interest to essential hospitals is a proposal to cut $14.6 billion from Medicare indirect medical education (IME) payments over 10 years. This represents the largest ever proposed cut to IME. However, the budget proposes to create a "new [grant-funded] competitive graduate medical education (GME) program that incentivizes high-quality physician training." At only $5.2 billion over 10 years, this program would fall far short of restoring the lost IME funds. The budget would also cut more than $30 billion over 10 years from Medicare payments for bad debt.

The budget includes relatively fewer cuts to Medicaid compared with Medicare. Consistent with previous proposals, the budget proposes to extend existing Medicaid DSH cuts for an additional year, to FY 2024, a process commonly referred to as "rebasing" the DSH cuts. The budget proposes several provisions that would benefit

patients of essential hospitals by extending the Qualified Individual and Transitional Medical Assistance programs through FY 2015 and permanently extending express-lane eligibility, which makes it easier for providers to connect patients to Medicaid coverage.

Continued Rollout of Affordable Care Act

America's Essential Hospitals partnered with the White House policy and communications departments throughout the early months of this year to promote the successes hospitals achieved in helping patients obtain services using new coverage gained through the health insurance exchanges. Given the negative media attention during the enrollment period when the healthcare.gov website was not functioning, the White House was very eager to promote success stories once patients could begin to use their new coverage. Essential hospitals, which have a wealth of experience in helping patients navigate the insurance landscape, were able to share many success stories, and America's Essential Hospitals was able to promote our members' good work.

Debt Ceiling Debate

Although we have seen a contentious debate over the past several years any time the federal government has come close to hitting its statutory debt limit ceiling, in February, Congress easily passed a clean bill to raise the debt limit so that the federal government can borrow money through March 15, 2015. Although Speaker Boehner had tried to pass debt ceiling legislation that included a repeal of cuts to military retirement pensions, ultimately his caucus could not agree on concessions and the bill was passed without strings attached. So, at least until next spring, we likely will not see any debate or legislation pertaining to the debt ceiling.

Changing Leadership on the Hill

Longtime chair of the Senate Finance Committee, Sen. Max Baucus (D-MT), was confirmed in February to serve as the new ambassador to China. Sen. Ron Wyden (D-OR) assumed the role of chair. Wyden has risen quickly in seniority on the committee: In 2010, he was the number 7 Democrat out of 13, but due to a number of Democratic losses, retirements, and administration appointments, he was next in line when Baucus stepped down this year. Wyden has stated that his top priorities in this role include tax reform, protecting Medicare, competitiveness overseas, and access to quality, affordable health care. To build a stronger relationship with Wyden, America's Essential Hospitals is planning to hold a fundraiser for the senator later this spring. More information will be shared with you during the board meeting.

Top Association Advocacy Issue in 2014 – Defining Essential Hospitals

With the exception of the need to permanently fix or temporarily patch the SGR, we expect little other legislation to move during this election year. Thus, one of our key advocacy goals of 2014 is to continue to educate policymakers about what essential hospitals do and what distinguishes essential hospitals from other providers. This is, in

essence, a second phase of our rebranding effort and carries through on the designation concept the board approved at its June and September meetings last year. In our advocacy efforts, we have begun to define essential hospitals as the leading providers in their communities who fulfill multiple missions and provide care to all patients, particularly the most vulnerable. Essential hospitals are unique because of the services they provide and the populations they serve. Specifically, essential hospitals

- are committed—which they demonstrate through practice—to providing a disproportionate amount of care to vulnerable populations, especially to patients covered by Medicaid or who are uninsured;
- train the next generation of clinicians at levels greater than other hospitals;
- provide comprehensive, coordinated care to patients in their communities;
- provide specialized, high-acuity care to patients, often as the sole provider of that care in their community; and
- advance public health and essential community services.

We remain firmly committed to the idea of a federal designation that recognizes essential hospitals. However, given the political and fiscal climate today, we recognize that standalone legislation promoting such a designation is unlikely to advance far. Rather, we seek opportunities to advance the designation concept through smaller-scale policies. By using a foot-in-the-door approach, we hope to incrementally advance the idea that essential hospitals are special, and thus, should be treated differently. For example, in a recent comment letter to the Center for Consumer Information and Insurance Oversight (CCIIO) regarding its guidance to exchanges on the inclusion of essential community providers (ECPs) in their networks, we recommended that CCIIO should develop specific requirements around network inclusion of essential hospitals, defined as those that generally fulfill the above criteria.

Our goal is to continue to advance the idea of an essential hospital, defined by our framework, so that it becomes a natural part of the lexicon when policymakers discuss hospitals. So, when the political climate is right to introduce legislation that would codify in law the definition of an essential hospital, such an idea would be viewed as a natural next step in the discussion.

We already have seen a shift in terminology toward "essential" in our conversations on Capitol Hill, in communications with other policy stakeholders, and in the mass media. For example, shortly after we rebranded last year, a George Washington University School of Public Health and Health Services report on immigration reform and health care noted impacts to "community health centers and essential hospitals." More recently, Erlanger Health System's chief of staff, in a letter to the editor on the hospital's future, referred to Erlanger as the "region's essential hospital."

This effort will be ongoing, in this Congress and beyond. But, we believe that through a dedication to this vision that unites our membership, we will be able to deliver

significant benefits to our members and, most important, allow you to continue to provide to your communities the unique and vital services that you alone provide.

Member Education Efforts and Advocacy on Delivery System Transformation Waivers

In 2014, the association will focus on member education and regulatory advocacy efforts around Medicaid delivery system transformation waivers. We will conduct a series of webinars on waiver topics, including sharing clinical quality results from hospitals already working in waiver programs; publish policy and research papers; and include an education track on waivers at this year's annual conference, VITAL2014. In addition, the policy advisory committee will be engaged in a project to define principles for the development of Medicaid alternative payment models, which we will use in the second half of this year for waiver education efforts.

Engagement on Contracts with Qualified Health Plans through the Exchanges

Ensuring members' full participation in the federally facilitated exchanges (marketplaces) has been a recent regulatory focus for America's Essential Hospitals. We have commented numerous times over the past year to the White House, to Centers for Medicare & Medicaid Services (CMS) leadership, and to CCIIO staff about the need for stronger rules regarding the exclusion of essential hospitals in the networks of qualified health plans (QHPs). On February 4, CCIIO released a draft letter that provides guidance to issuers that plan to offer QHPs in marketplaces in 2015. The draft letter takes several steps in the right direction with regard to the participation of essential hospitals, although further strengthening is warranted. Of particular interest to members of America's Essential Hospitals, the letter details guidance on QHP inclusion of ECPs. The agency proposes to utilize a general standard for 2015 that would require each QHP network to include at least 30 percent of all available ECPs in their service areas. This is an increase from the 2014 general standard of 20 percent.

In its comment letter to CCIIO, America's Essential Hospitals urged the agency to require issuers to offer good-faith contracts to all ECP hospitals in the plan's service area and develop specific requirements around the inclusion of essential hospitals. The association stated that including ECPs in QHP networks helps patients maintain access to services and continuity of care. Furthermore, to ensure vulnerable populations continue to have sufficient and timely access to critical hospital services, QHP contracts must adequately and fairly pay for these services—which may not be provided elsewhere in the community.

America's Essential Hospitals will continue to advocate on this issue on behalf of our members. For example, we are hosting a speaker from CCIIO at the spring Policy Assembly meeting who will address this issue, among others, and we will continue to keep members informed of CCIIO's regulations.

Expecting 340B Regulations in Early Summer

In response to congressional criticism that it does not provide sufficient oversight of the 340B Drug Pricing Program, the Health Resources and Services Administration

(HRSA) is planning to issue a large regulation in June, referred to as the "mega-reg," that would put into formal regulation all of the program guidance for administration of the 340B program. Little is known about exactly what will be in the guidance, but it should be assumed that most elements of the program, such as the definition of a patient and how to work with contract pharmacies, will be included. America's Essential Hospitals is anticipating the release of this regulation, which will have a formal notice and comment period. While we believe we will not agree with everything HRSA includes in the proposed rule, we are pleased the agency will begin to issue guidance through notice and comment. This will safeguard hospitals' rights to provide feedback to HRSA on the administration of the program, something that often was not possible when HRSA issued guidance through informal processes, such as through frequently asked questions documents.

AMERICA'S ESSENTIAL HOSPITALS

DATE	March 24, 2014
TO	Board of Directors
FROM	David Engler, PhD, Senior Vice President, Leadership & Innovation
RE	Impact of Value Based Purchasing Program on America's Essential Hospitals

MEMORANDUM

Under the value based purchasing program (VBP) required by the Affordable Care Act, Medicare payments were reduced initially by 1 percent to fund a pool for incentive payments to hospitals that met or exceeded performance standards in process of care measures and patient experience of care. The withholds increase to a maximum of 2 percent in fiscal year (FY) 2017; additional measures, such as mortality outcomes and efficiency measures, are added over time; and the weights used to calculate the VBP scores will change. The VBP program was designed to be budget neutral so that incentive payments will not exceed withholds.

This memo examines the total financial impact of VBP on our member hospitals in the first two years of the program (FY 2013 and FY 2014).

Data

CMS released FYs 2013 and 2014 VBP adjustment factors in December 2012 and October 2013, respectively. Under contract for America's Essential Hospitals, the Healthcare Association of New York State (HANYS) used Centers for Medicare & Medicaid Services (CMS) data from the impact file of the inpatient prospective payment system (IPPS) final rules to estimate the base operating diagnosis-related group (DRG) payments for members. Actual VBP adjustment factors were applied to these DRG payment estimates to approximate bonus and penalty amounts.

Findings

Members of America's Essential Hospitals lost money under VBP in both FY 2013 and FY 2014 (Table 1). An estimated impact of $5.3 million in FY 2013 declined to $3.8 million in 2014. A comparison of hospitals having all measures reported for both years shows a similar impact, as well as declining losses under the program ($5.15 million in FY 2013 and 3.84 in FY 2014).

Table 1. Estimated Dollar Impacts

	FY 2013	FY 2014	Net Change from FY 2013 to FY 2014
Number of Members Eligible for VBP Program	113	98	15*
Number of Members Earning Money	33	33	no change
Number of Members Losing Money	77	64	13
Total Impact for All Eligible Members	-$5,294,000	-$3,843,000	$1,451,000
Total Impact for Only Members Eligible for Both FY2013 and FY2014**	-$5,151,000	-$3,843,000	$1,308,000
Average Member Base-DRG	$4,138,011,781	$4,166,678,547	$28,66,766
Average U.S. Hospital Base-DRG	$86,014,112,396	$86,950,963,601	$936,851,205

*The number of hospitals eligible in FY 2013 that were not eligible in FY 2014 dropped due to the inclusion of the mortality measures; these hospitals did not meet the minimum reporting requirements for at least two of the three mortality measures.
**This figure excludes hospitals that were not eligible for the VBP program for one or both years. Only hospitals that were eligible for the program for both FY 2013 and FY 2014 (N=98) are included in this figure.

Total aggregate losses dropped between the two years due to improvements in member hospitals' scores, primarily at the top end of the distribution (Figure 1). The better performing hospitals got better and at a faster rate of change than hospitals in the lower quartiles. Note the slopes at the 90th and above percentiles versus the bottom 10th percentile.

The bubble chart (Figure 2) shows that while the number of member hospitals earning money stayed the same between the two fiscal years, the number of hospitals losing money under VBP and the amount of their losses declined. Note the shift down and in.

Figure 1. Interquantile Change FY 2013 and 2014 VBP Penalty/Bonus

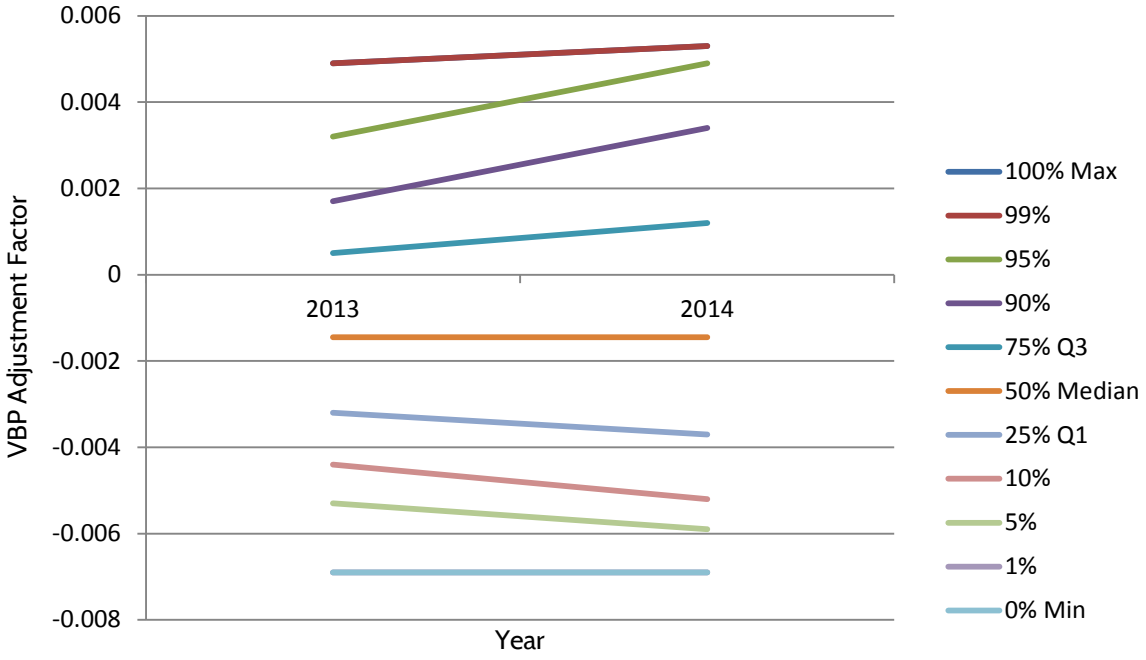
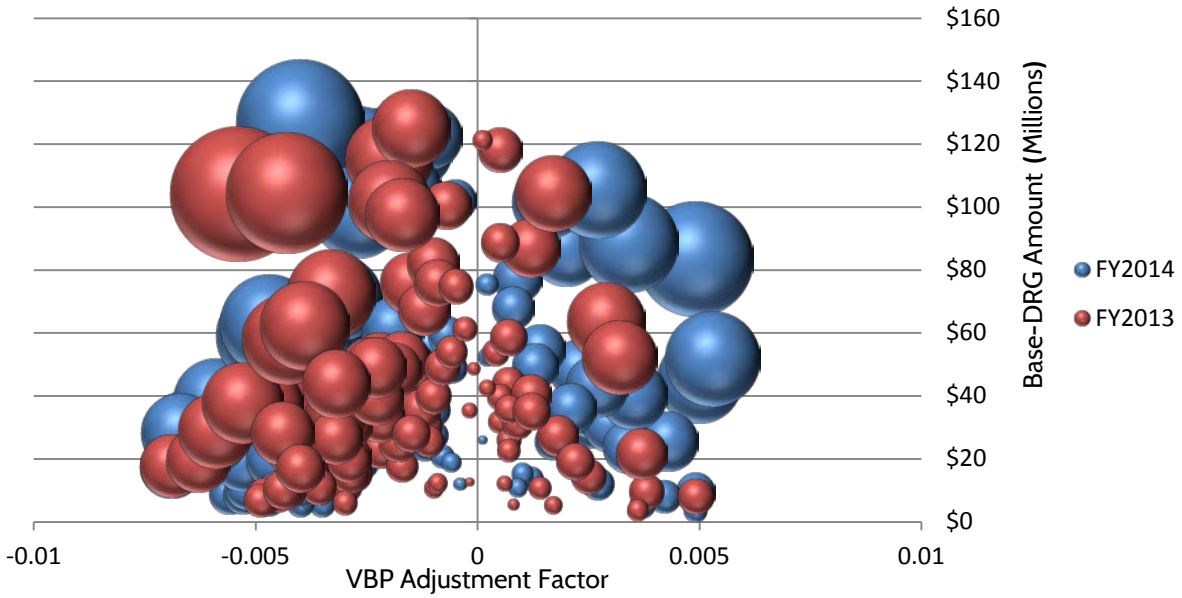


Figure 2. Bubble Chart of Impact Factor versus Base-DRG Payments

Bubble Size indicates estimated bonus/penalty amount



Summary

- VBP during the first two years of the program had only a modest financial impact on members of America's Essential Hospitals in the aggregate.

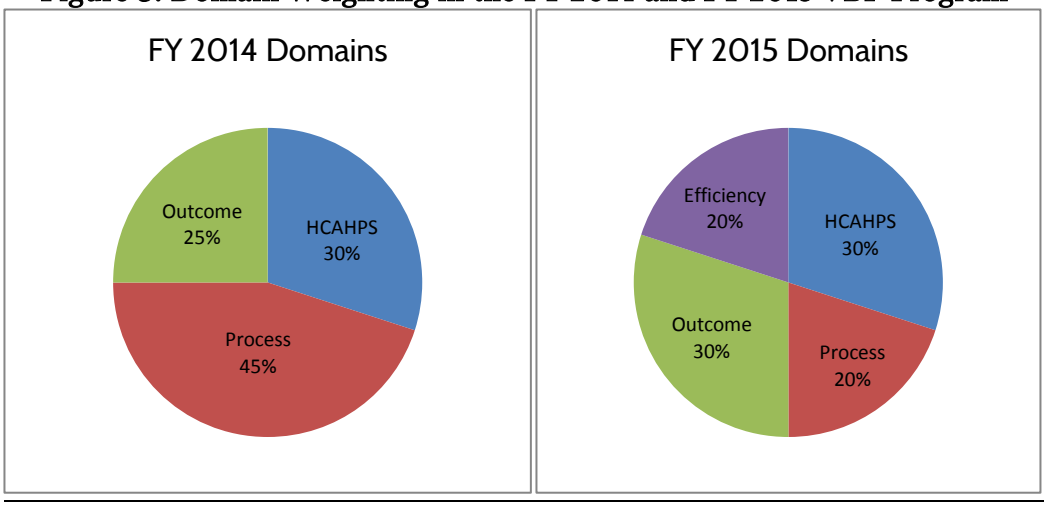
- Individual member losses in FY 2014 ranged from $5,000 to $506,000, while gains from VBP ranged from $3,000 to $409,000.
- Members of America's Essential Hospitals perform better than hospitals nationally on outcomes measures (Table 2). Members' Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and process scores generally run below the national, but have been improving over time.

Table 2. Member Performance on the FY 2014 VBP Domains as Compared with the National Average and Median

FY 2014	Average		Median	
	Member	National	Member	National
Weighted HCAHPS Domain Score	9.27	12.14	7.95	11.7
Weighted Process Domain Score	24.75	26.59	23.63	27.00
Weighted Outcomes Domain Score	8.91	7.87	8.33	7.50

- Our outlook for VBP in FY 2015 is guardedly optimistic, as domain weights will shift toward measures on which our members perform well. Efficiency measures are being added to the VBP domains at a 20 percent weighting (Figure 3) and outcomes measures will have increased weights, while process of care measures and HCAHPS, the domains on which our members don't do as well, will have lower weighting.

Figure 3. Domain Weighting in the FY 2014 and FY 2015 VBP Program



AMERICA'S ESSENTIAL HOSPITALS

DATE	March 24, 2014	
TO	Board of Directors	
FROM	David Engler, PhD, Senior Vice President, Leadership & Innovation	
RE	Hospital Readmissions Reduction Program	MEMORANDUM

Under the Centers for Medicare & Medicaid Services (CMS) Hospital Readmissions Reduction Program (HRRP), hospitals paid under the inpatient prospective payment system (IPPS) are penalized for readmissions that occur within 30 days of an index admission that exceed expected levels. The penalties increase over time, beginning with a 1 percent penalty on inpatient Medicare revenue for fiscal year (FY) 2013 and a 2 percent penalty for FY 2014[1]. This memo examines both the impact of these penalties on our members and the distribution of these penalties among member and non-member hospitals in the program's first two fiscal years.

Data

CMS released FYs 2013 and 2014 HRRP readmission reduction factors in March 2013 and August 2013, respectively. Under contract for America's Essential Hospitals, the Healthcare Association of New York State (HANYS) used CMS data from the impact file of the IPPS final rules to estimate the impact on base operating diagnosis-related group (DRG) payments for member and non-member hospitals. We merged disproportionate patient percentage (DPP) data from the impact file with the readmission reduction factors by Medicare provider number.

Findings

Estimates show that payment penalties for members of America's Essential Hospitals were $17.65 million in FY 2013 and $14.8 million in FY 2014, representing a decrease of 16.4 percent. During this period, IPPS hospitals experienced an 18.9 percent reduction in payment penalties. In addition, our members' share of the total penalties dropped from 6.6 percent to 6.5 percent. (Table 1)

[1] CMS will increase penalties to 3 percent in FY 2015 and expand the list of applicable conditions to include conditions such as COPD, in addition to AMI, heart failure, and pneumonia, which were subject to penalties in FYs 2013 and 2014.

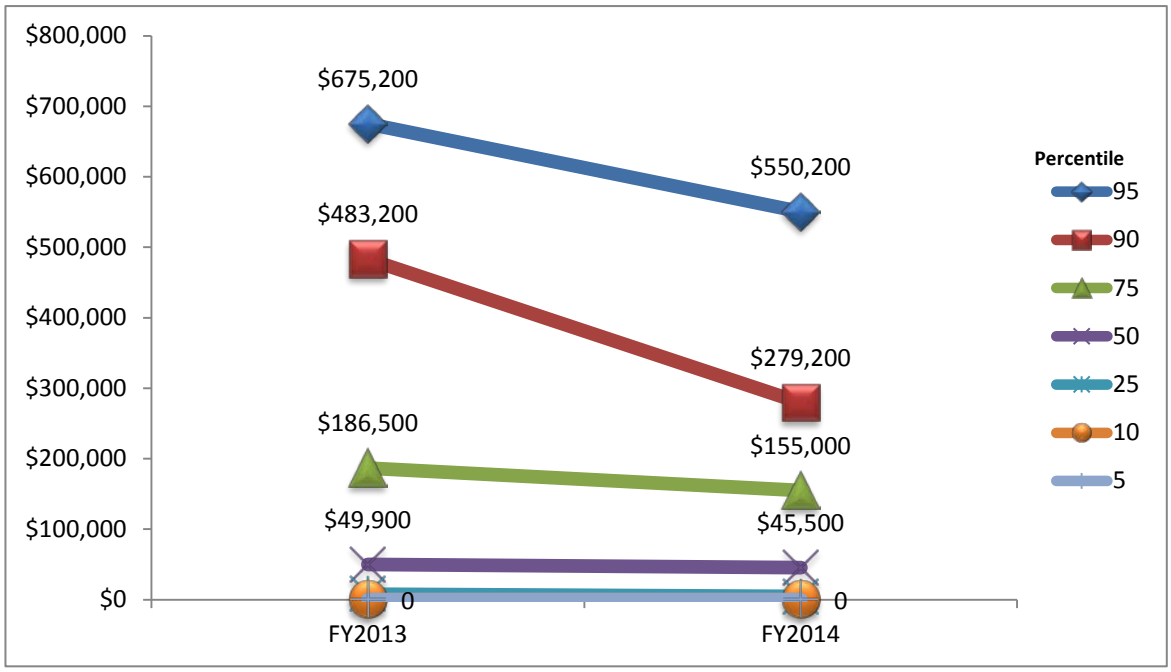
Table 2. Estimated Dollar Impacts

	FY 2013		FY 2014	
	Estimated Base Operating DRG Payments Subject to the HRRP	Estimated Dollar Impact (Annual)	Estimated Base Operating DRG Payments Subject to the HRRP	Estimated Dollar Impact (Annual)
U.S.	$86,014,112,396	-$280,000,000*	$86,590,963,601	-$227,000,000*
America's Essential Hospitals	$4,222,005,841	-$17,765,000	$4,251,520,387	-$14,842,800
	4.9%	6.6%	4.9%	6.5%

*These estimates based on CMS IPPS final rules for fiscal years 2013 and 2014, repectively

The distribution of payment penalties shifted between the two years. Median payment penalties declined nationally and within our membership. Members who were impacted most by the HRRP, placing them in the 90th percentile of our membership, experienced the largest decrease in penalties. (Figure 1)

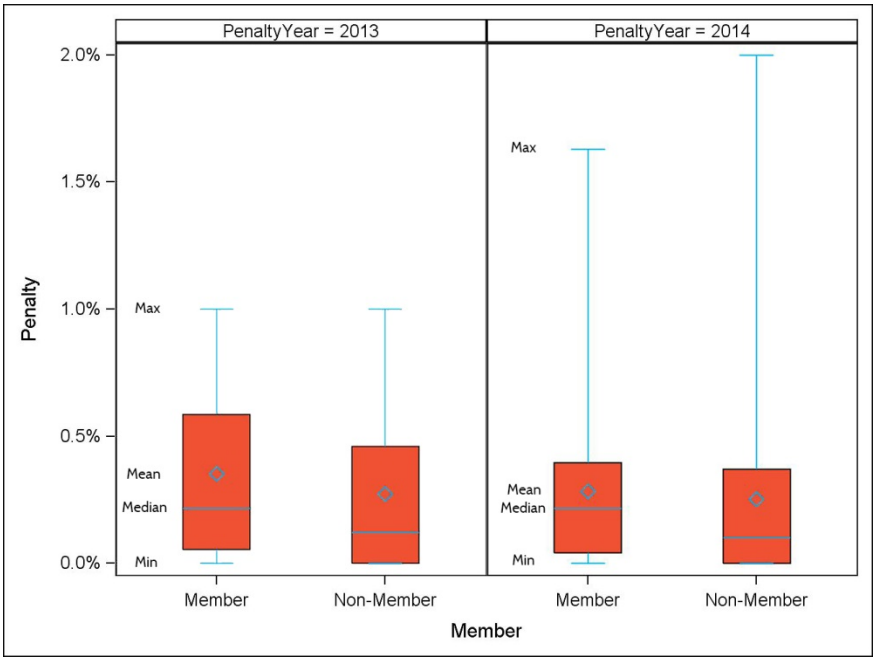
Figure 1. Estimated Impact of the HRRP on America's Essential Hospitals Members



Members with the largest penalties in FY 2013 saw the quickest decline in penalties between the two years.

With respect to distribution of penalties, members of America's Essential Hospitals had higher median penalties in both fiscal years relative to non-member hospitals. (See Figure 2.) In FY 2014, 67 percent of our members saw greater penalties than the national median penalty. In addition, 17.2 percent of our members did not incur a penalty in FY 2014, compared with 34.8 percent of non-members. An America's Essential Hospitals analysis found that there was a weak but statistically significant correlation between penalties and DPP for all hospitals (r= .17 in FY 2013, r=.15 in FY 2014). Other studies, including by Kaiser Health News and the Commonwealth Fund, came to similar conclusions.

Figure 2. Distribution of Penalties, Member versus Non-Member



Summary

- Although median HRRP payment penalties declined nationally and within our membership between FY 2013 and FY 2014, members of America's Essential Hospitals had higher median penalties in both FY 2013 and FY 2014 relative to non-members.
- Based on these early results and the total value of the penalties, we should discuss whether the association should invest significant resources in efforts to alter the payment penalty formula.
- Moreover, as CMS adds new medical conditions to the "penalty box," we should model their impact based on our hospitals' patient populations.

AMERICA'S ESSENTIAL HOSPITALS

DATE March 24, 2014
TO Board of Directors
FROM Rhonda Gold
RE Financial Update

MEMORANDUM

This memorandum updates you on the 2013 financial results compared with the last projection, presented in December, and presents proposed revisions to the 2014 approved budget. Our audit fieldwork began February 24; audited financial statements will be forwarded to you once they are finalized and reviewed by the audit and compliance committee. For your information, copies of the auditor's engagement and planning letters are included with this material.

Please note that staff is asking the board to vote on the following action items, as explained in this memo:

- Revise the 2014 approved budget to reflect the elimination of $485,000 in support to Essential Hospitals Institute and reallocation of these budgeted funds to the salaries, fringe benefits, and office relocation lines.
- Approve the revised 2014 budget.

2013:
Attachment I presents an update of 2013 income and spending, compared with the approved budget and with the last projection, presented in December (based on actuals through October). For informational purposes, a Statement of Financial Position is presented in Attachment II.

America's Essential Hospitals ended the year with 2013 income of $8.07 million, which is offset by almost $6.78 million in expenses, leaving an operating surplus of $1.29 million before rebranding costs funded from reserves (of $166,000) and investment gains (of $395,500). This surplus is $419,500 better than last projected, primarily due to savings in project development costs ($100,000); salaries and fringe benefits ($67,000); advertising campaigns ($95,000); office expenses ($34,000); and travel and professional development ($33,000). After accounting for last year's beginning net assets, total 2013 net assets are almost $6.8 million, an increase of $672,000 from last projected. This net asset balance represents one year of operating expenses in reserves.

2014 Update:
Attachment II presents the approved budget and a proposed revised budget, which reflects two notable changes. Based on documentation received from the Centers for Medicare & Medicaid Services (CMS) acknowledging the change in scope for the Partnership for Patients initiative, the auditors have reclassified the Institute's unexpended 2012 and 2013 budget funds from a liability and recognized it as earned revenue in 2013. This reclassification amounts to $4.3 million in revenue and is reflected in the ending net asset balance on the Institute's financial statements. Because of this reclassification, the contribution (of $485,000) from the association is no longer needed to support uncovered Institute labor and programmatic costs for research work and the Transformation Center. W**e are pleased to report that, for the first time in its history, the Institute is self-supporting, thus accomplishing an organizational goal**. The organization's leadership team will develop proposals for spending these funds on new programs or expanding current ones, and will present these ideas to the Institute board once they are developed.

To offset this savings, we plan to use these funds to cover salary market adjustments recommended by our outside consultant, RSC Advisory Group. After conducting a CEO and staff-wide compensation study (the most recent one was in 2010), the findings indicate that many positions were paid, on average, 10 percent below market. To retain and recruit talented staff, the compensation committee adjusted the CEO's salary to market, and we tried to do the same, as much as possible, for staff. We are hiring an additional lobbyist to assist in promoting the concept of a federal designation for our members and to support advocacy to further repeal or delay Medicaid disproportionate share hospital cuts. The addition of a lobbyist also will enable us to expand and deepen relationships on Capitol Hill during a time of increased turnover among both members of Congress and their staffs. The budget implications for these changes are $273,000 to the association.

Long-term Forecast:
As we refine the budget number for the association's move to new office space, we have found that it substantially exceeds our initial estimates. At this early juncture in the planning phase, our architects estimate an office space footprint of 17,000 to 20,000 square feet to accommodate a large board room and staff growth. Because our current rental rate is *significantly* below market, we can expect to see up to a 65 percent increase in the square footage cost (increasing our rent from $42.50 to $70 per square foot). Our annual rent expense could increase from $780,000 to $1.4 million, assuming a new office of 20,000 square feet. We are hopeful the landlord will offer an eight- to 10-month rent abatement to offset some of these costs. However, for financial statement purposes, this abatement is amortized over the length of the lease (10 years, 11 months).

We are estimating a total office move budget of $4 million (for 20,000 square feet), of which $1.7 million should be reduced by a landlord's tenant improvement allowance, for a net cost of $2.3 million. This estimate includes build-out costs for the architect and construction, audio-video infrastructure, furniture, a telephone system, computers, and office move expenses. Many of these expenses are depreciable over a three- to five-year period, while the space build-out is amortizable over the life of the lease (assuming 10

years). We will keep you apprised of this budget as we move forward, as these are very preliminary estimates.

To account for these costs, an updated financial forecast is presented in attachments III and IV for the association *and* Institute. Attachment III presents our current dues structure, with two new members per year and 20,000 square feet of space. Attachment IV reflects our proposed dues restructure with a net loss of two members in 2015, a net gain of two new members in 2016 and 2017, and 20,000 square feet of space.

The purpose of this forecast is to project the amount of revenue enhancements, expense reductions, or a combination that the organization would need to maintain an annual 5 percent profit margin. Because of the move and increased personnel costs, we will have to make some difficult decisions to meet a 5 percent profit margin. The last three columns (2015-2017) present scenarios for expense reductions or income increases (or combination) to maintain a 5 percent profit margin, under the following assumptions:

Revenue:

- dues revenue: 5 percent annual dues increase and net gain of two full members annually (under our current dues structure)
- UHC dues and sponsorships: 2 percent annual increase
- external sponsorships: 2 percent annual increase
- grants and contracts:
    - 2015 assumes no Kaiser Permanente (KP) core funding of the Transformation Center (grant ends December 2014); $428,000 for KP collaboration with the National Association of Community Health Centers; and $258,000 in new funding.
    - 2016 and 2017 assume $312,000 in grant funding.
    - Our Partnership for Patients contract is assumed to be renewed each year.
- program fees: 3 percent annual increase

Expenses:

- personnel: 4 percent merit increases; executive compensation changes based on market; 25 percent increase in health insurance premiums, starting in 2015; and same FTEs as in 2014
- consultants/subcontractors (non-grant): 3 percent inflationary increase
- operations and programmatic expenses: 3 percent inflationary increase
- rent: 20,000 square feet at $70 per square foot in 2016, increased by 4 percent in 2017; assumes an eight-month rent abatement amortized over 10 years ($86,000 per year)
- project development costs: $200,000 annually
- Office build-out and relocation expenses of $735,000 in 2015 and $453,000 in 2016 and 2017; many of these expenses represent the depreciable or amortizable cost over three, five, and 10 years, 11 months.

We are making a conscious decision to expand the association's non-dues based revenue by hiring a new manager of innovation and partnerships. This position will report to the senior vice president of leadership and innovation and be responsible for developing the Transformation Center's new initiatives in clinical transformation and innovation and expanding our business opportunities. The personnel costs for this unbudgeted position are reflected in the Institute's revised budget.

To cover the additional rental costs and the build out, we would need to implement new revenue enhancements, expense reductions, or a combination. Under the existing dues structure, these measures would equate to an 8 percent to 9 percent reduction in overall annual operating expenses, revenue enhancements, or a combination. Under the dues restructure, these measures would equate to a 6 percent to 7 percent change.

We are hopeful that by recruiting new members, seeking additional non-dues revenue and grant funding opportunities, and reducing operating expenses, we will achieve our profit margin goal. As we have better budget estimates for the move, we will share those with you.

Attachment I: 2013 financial update
Attachment II: Statement of Financial Position as of December 31, 2013
Attachment III: 2014 budget
Attachment IV: Three-year financial forecast under *current* dues structure
Attachment V: Three-year financial forecast under dues *restructure*

Attachment I

2013 Financial Results

	col 1 **2013 Year-End Proj**	col 2 **2013 Audit**	col 3 **Audit vs Year-end proj**	col 4 **% variance**
INCOME:				
Membership Dues	$ 4,630,700	$ 4,627,383	$ (3,317)	0%
UHC Membership Dues	$ 2,831,400	$ 2,831,400	$ -	0%
UHC Sponsorships	$ 250,000	$ 250,000	$ -	0%
Other sponsorships	$ 209,500	$ 204,495	$ (5,005)	-2%
GR Academy	$ 44,000	$ 44,000	$ -	0%
Annual Conference	$ 104,200	$ 112,235	$ 8,035	8%
Publication Sales/Misc.	$ 5,400	$ 5,400	$ -	0%
TOTAL INCOME	**$ 8,075,200**	**$ 8,074,913**	**$ (287)**	**0%**
EXPENSE:				
RETAINER	$ 400,000	$ 400,000	$ -	0%
SALARIES & FRINGES	$ 3,455,000	$ 3,387,832	$ 67,168	2%
Policy	$ 189,000	$ 175,894	$ 13,106	7%
Advocacy	$ 454,100	$ 439,371	$ 14,729	3%
Member Services	$ 193,200	$ 191,307	$ 1,893	1%
Consulting/Prof Fees	$ 157,000	$ 147,195	$ 9,805	6%
Information Technology	$ 91,000	$ 67,588	$ 23,412	26%
Rent	$ 393,300	$ 339,283	$ 54,017	14%
Office expenses/equipment rental	$ 191,500	$ 157,569	$ 33,931	18%
Communications	$ 243,800	$ 148,245	$ 95,555	39%
Conferences	$ 404,300	$ 456,255	$ (51,955)	-13%
Travel and Prof Development	$ 102,000	$ 68,562	$ 33,438	33%
Taxes, Insurance and Misc.	$ 66,000	$ 61,031	$ 4,969	8%
Depreciation/Amortization	$ 58,000	$ 38,247	$ 19,753	34%
Project Development/Moving expenses	$ 100,000	$ -	$ 100,000	100%
Contribution /Support to Institute	$ 700,000	$ 700,000	$ -	0%
TOTAL EXPENSE	**$ 7,198,200**	**$ 6,778,379**	**$ 419,821**	**6%**
Changes in Net Assets before funding from reserves	**$ 877,000**	**$ 1,296,534**	**$ 419,534**	
Other Items funded from Reserves:				
Rebranding (including depreciation on website)	($175,000)	($166,322)	$8,678	
Changes in Net Assets, after funding from reserves	**$ 702,000**	**$ 1,130,212**	**$ 428,212**	
Non-Operating Income:				
Interest/Dividend Income	$ 48,000	$ 147,325	$ 99,325	
Realized Capital Gains/(Losses)	$ 3,000	$ 3,762	$ 762	
Unrealized Gains/(Losses)	$ 100,000	$ 244,375	$ 144,375	
Total Non-Operating Income/(Loss)	**$ 151,000**	**$ 395,462**	**$ 244,462**	**$ -**
Changes in Net Assets, after Non-Operating Income	**$ 853,000**	**$ 1,525,674**	**$ 672,674**	
NET ASSETS:				
Prior Year Net Assets	**$ 5,274,045**	**$ 5,274,045**	**$ -**	
Change in Net Assets	**$ 853,000**	**$ 1,525,674**	**$ 672,674**	
Total Net Assets after funding of special projects	**$ 6,127,045**	**$ 6,799,719**	**$ 672,674**	
Contribution to Restricted Net Assets:				
Office Relocation (restricted net assets)	$ (150,000)	$ (150,000)	$ -	
Total Contribution to Restricted Net Assets	**$ (150,000)**	**$ (150,000)**	**$ -**	
Summary of Total Net Assets:				
Unrestricted Net Assets	$ 5,877,045	$ 6,549,719	$ 672,674	
Restricted Net Assets for office relocation	$ 250,000	$ 250,000	$ -	
Total Net Assets	**$ 6,127,045**	**$ 6,799,719**	**$ 672,674**	

Attachment II

AMERICA'S ESSENTIAL HOSPITALS

STATEMENT OF FINANCIAL POSITION
AS OF DECEMBER 31, 2013

ASSETS

CURRENT ASSETS		
Cash and cash equivalents	$	4,731,940
Investments	$	5,203,984
Accounts receivable	$	39,367
Due from EHEN	$	134,662
Prepaid expenses	$	107,953
Total current assets	$	10,217,906
FURNITURE, EQUIPMENT AND LEASEHOLD IMPROVEMENTS		
Furniture and equipment	$	984,668
Leasehold and improvements	$	324,089
Software	$	24,154
	$	1,332,911
Less accumulated depreciation and amortization	$	(1,017,858)
Net furniture, equipment, and leasehold improvements	$	315,053
OTHER ASSETS		
Asset held for deferred executive compensation	$	868,998
Deposits	$	20,503
Total other assets	$	889,501
Total assets	$	**11,422,460**

LIABILITIES AND NET ASSETS

Current Liabilities		
Accounts payable	$	230,941
Accrued salaries and related benefits	$	683,610
Deferred revenue:		
Membership dues	$	2,520,800
Others	$	50,330
Due to Institute	$	79,655
Total current liabilities	$	3,565,336
LONG-TERM LIABILITIES:		
Deferred executive compensation plan	$	962,583
Deferred rent liability	$	94,821
Total long-term liabilities	$	1,057,404
Total liabilities	$	4,622,740
NET ASSETS		
Unrestricted	$	6,799,720
TOTAL LIABILITIES AND NET ASSETS	$	**11,422,460**

Attachment III

2014 Revised Budget

	2013 Audit	2014 Approved Budget	2014 Revised Budget	Budget Change
INCOME:				
Membership Dues	$ 4,627,383	$ 5,153,100	$ 5,153,100	$ -
UHC Membership Dues	$ 2,831,400	$ 2,992,000	$ 2,992,000	$ -
UHC Sponsorships	$ 250,000	$ 158,000	$ 158,000	$ -
Other sponsorships	$ 204,495	$ 245,000	$ 245,000	$ -
Annual Conference	$ 112,235	$ 136,600	$ 136,600	$ -
Waiver Seminar	$ -	$ 25,600	$ 25,600	$ -
TOTAL INCOME	**$ 8,074,913**	**$ 8,710,300**	**$ 8,710,300**	**$ -**
EXPENSE:				
RETAINER	$ 400,000	$ 400,000	$ 400,000	$ -
SALARIES & FRINGES	$ 3,387,832	$ 3,867,000	$ 4,140,000	$ (273,000)
Policy	$ 175,894	$ 246,700	$ 246,700	$ -
Advocacy	$ 439,371	$ 456,000	$ 456,000	$ -
Member Services	$ 191,307	$ 232,500	$ 232,500	$ -
Consulting/Prof Fees	$ 147,195	$ 135,000	$ 135,000	$ -
Information Technology	$ 67,588	$ 114,000	$ 114,000	$ -
Rent	$ 339,283	$ 384,200	$ 384,200	$ -
Office expenses/equipment rental	$ 157,569	$ 223,100	$ 223,100	$ -
Communications	$ 148,245	$ 307,600	$ 307,600	$ -
Conferences	$ 456,255	$ 612,200	$ 612,200	$ -
Travel and Prof Development	$ 68,562	$ 125,500	$ 125,500	$ -
Taxes, Insurance and Misc.	$ 61,031	$ 69,000	$ 69,000	$ -
Depreciation/Amortization	$ 38,247	$ 75,500	$ 75,500	$ -
Project Development/Moving expenses	$ -	$ 100,000	$ 312,000	$ (212,000)
Contribution /Support to Institute	$ 700,000	$ 485,000	$ -	$ 485,000
TOTAL EXPENSE	**$ 6,778,379**	**$ 7,833,300**	**$ 7,833,300**	**$ -**
Changes in Net Assets before funding from reserves	**$ 1,296,534**	**$ 877,000**	**$ 877,000**	**$ -**
Other Items funded from Reserves:				
Rebranding (including depreciation on website)	($166,322)	$ (100,000)	$ (100,000)	$ -
Changes in Net Assets, after funding from reserves	**$ 1,130,212**	**$ 777,000**	**$ 777,000**	**$ -**
Non-Operating Income:				
Interest/Dividend Income	$ 147,325	$ 50,000	$ 50,000	$ -
Total Non-Operating Income/(Loss)	**$ 395,462**	**$ 50,000**	**$ 50,000**	**$ -**
Changes in Net Assets, after Non-Operating Income	**$ 1,525,674**	**$ 827,000**	**$ 827,000**	**$ -**
NET ASSETS:				
Prior Year Net Assets	**$ 5,274,045**	$ 6,799,719	$ 6,799,719	$ -
Change in Net Assets	**$ 1,525,674**	$ 827,000	$ 827,000	$ -
Total Net Assets after funding of special projects	**$ 6,799,719**	**$ 7,626,719**	**$ 7,626,719**	**$ -**
Contribution to Restricted Net Assets:				
Office Relocation (restricted net assets)	$ (150,000)	$ (100,000)	$ (100,000)	$ -
Total Contribution to Restricted Net Assets	**$ (150,000)**	**$ (100,000)**	**$ (100,000)**	**$ -**
Summary of Total Net Assets:				
Unrestricted Net Assets	$ 6,549,719	$ 7,276,719	$ 7,276,719	$ -
Restricted Net Assets for office relocation	$ 250,000	$ 350,000	$ 350,000	$ -
Total Net Assets	**$ 6,799,719**	**$ 7,626,719**	**$ 7,626,719**	**$ -**

ATTACHMENT IV

Assumptions:

- New Lobbyist and 2 new research positions and Manager of Innovations
- Current Dues Structure with 2 new members per year

Goal of 5% profit margin

CURRENT DUES STRUCTURE

Two new members per year, 5% dues increase
assumes 20,000 sq ft for new space

existing dues structure

Dues	2013 actuals	2014 revised	2015	2016	2017	2015 Maintain 5% Margin Expense Reduction	2015 Maintain 5% Margin Income Increase	2016 Maintain 5% Margin Expense Reduction	2016 Maintain 5% Margin Income Increase	2017 Maintain 5% Margin Expense Reduction	2017 Maintain 5% Margin Income Increase
Revenue:											
Dues	$ 4,627,383	$ 5,153,100	$ 5,471,708	$ 5,872,963	$ 6,300,663						
UHC (note 2)	$ 3,431,400	$ 3,500,000	$ 3,570,000	$ 3,641,400	$ 3,714,228						
Sponsorships (note 2)	$ 204,495	$ 245,000	$ 249,900	$ 254,898	$ 259,996						
Grants (note 3)	$ 1,565,050	$ 1,694,569	$ 686,505	$ 317,000	$ 224,000						
Gov. Contract (note 4)	$ 3,584,687	$ 5,493,800	$ 5,692,500	$ 5,787,000	$ 5,885,000						
Gov. Contract (note 4)- release of deferred revenue	$ 4,308,143										
Program Fees (note 5)	$ 416,953	$ 454,700	$ 468,341	$ 399,991	$ 411,991						
Total Revenue	**$ 18,138,111**	**$ 16,541,169**	**$ 16,138,954**	**$ 16,273,252**	**$ 16,795,878**	$16,200,000	$17,600,000	$16,300,000	$18,000,000	$16,825,000	$18,525,000
rev enhancements						$61,047	$1,461,047	$26,748	$1,726,748	$29,122	$1,729,122
Expenses:											
Personnel (note 6), incl manager of innov	$ 7,016,785	$ 8,090,000	$ 8,700,000	$ 9,048,000	$ 9,409,920						
Retainer/Consultants/Subcontractors, non-contract (note 7)	$ 652,512	$ 655,000	$ 674,650	$ 694,890	$ 715,736						
Operations(note 8)	$ 656,900	$ 1,014,500	$ 1,044,935	$ 1,076,283	$ 1,108,572						
Rent (new space in 2016 for 20ksf @ $70 psf) (note 9)	$ 702,581	$ 733,800	$ 777,300	$ 1,400,000	$ 1,456,000						
Rent abatement (8 mos)-amortized over 10 yrs				$ (86,154)	$ (86,154)						
Grants/contracts, non-personnel (note 10)	$ 1,301,276	$ 2,527,646	$ 2,067,864	$ 1,812,700	$ 1,772,700						
Research, TC & Fellows, non-personnel (note 11)	$ 315,450	$ 457,800	$ 471,534	$ 485,680	$ 500,250						
Policy/Advocacy/Comms (note 11)	$ 764,040	$ 1,010,200	$ 1,040,507	$ 1,071,722	$ 1,103,874						
Mem Svc/Events (note 11)	$ 647,562	$ 842,600	$ 887,878	$ 914,514	$ 941,950						
Rebranding	$ 166,322	$ 100,000	$ 100,000	$ -	$ -						
Project Development	$ -	$ 200,000	$ 200,000	$ 200,000	$ 200,000						
Total Expenses, excl office move	**$ 12,223,428**	**$ 15,631,546**	**$ 15,964,668**	**$ 16,617,635**	**$ 17,122,848**						
Net surplus/(loss) before space buildout & move	**$ 5,914,683** **32.61%**	**$ 909,623** **5.50%**	**$ 174,286** **1.08%**	**$ (344,383)** **-2.12%**	**$ (326,970)** **-1.95%**						
Office build-out and office relocation expenses:											
Amortization of space buildout			$ 53,988	$ 53,988	$ 53,988						
Depreciation on new furniture and telephones			$ 399,667	$ 399,667	$ 399,667						
Signage/Office movers/consultants		$ 212,000	$ 281,380	$ -							
Office move related expenses	**$ -**	**$ 212,000**	**$ 735,034**	**$ 453,654**	**$ 453,654**						
Total Expenses, including office move	**$ 12,223,428**	**$ 15,843,546**	**$ 16,699,702**	**$ 17,071,289**	**$ 17,576,502**	$15,360,000	$16,699,702	$15,475,000	$17,071,289	$15,975,000	$17,576,502
exp reductions						($1,339,702)	$0	($1,596,289)	$0	($1,601,502)	$0
Net surplus/(loss) after space buildout & move	**$ 5,914,683** **32.61%**	**$ 697,623** **4.22%**	**$ (560,749)** **-3.47%**	**$ (798,037)** **-4.90%**	**$ (780,624)** **-4.65%**	$840,000 **5.19%**	$900,298 **5.12%**	$825,000 **5.06%**	$928,711 **5.16%**	$850,000 **5.05%**	$948,498 **5.12%**
Profit Margin Goal		**5.00%**	**5.00%**	**5.00%**	**5.00%**						

Expense Reductions on expenses necessary for 5% profit margin:

2015	($1,339,702)	-8%
2016	($1,596,289)	-9%
2017	($1,601,502)	-9%

ATTACHMENT V

DUES RESTRUCTURE
NET LOSS OF 2 MEMBERS IN 2015; NET GAIN OF 2 NEW MEMBERS THEREAFTER
calculation of rent cost to maintain 5% profit margin (20,000 sf)

Assumptions:
- New Lobbyist and 2 new research positions and Manager of Innovations
- Dues restructure with $65k and below immediately phased in; others over 2 year phase in by 2016
- 4 LOSSES resulting from the restructure in 2015, offset by GAIN of 2 NEW members (net loss of 2 members in '15)
- 2 NEW members resulting from dues restructure starting in 2016 and continuing into out-years

Goal of 5% profit margin

with dues restructure

Dues	2013	2014 revised	2015	2016	2017	2015 Maintain 5% Margin Expense Reduction	2015 Maintain 5% Margin Income Increase	2016 Maintain 5% Margin Expense Reduction	2016 Maintain 5% Margin Income Increase	2017 Maintain 5% Margin Expense Reduction	2017 Maintain 5% Margin Income Increase
Revenue:											
Dues	$ 4,627,383	$ 5,153,100	$ 5,705,304	$ 6,475,250	$ 6,942,338						
UHC (note 2)	$ 3,431,400	$ 3,500,000	$ 3,570,000	$ 3,641,400	$ 3,714,228						
Sponsorships (note 2)	$ 204,495	$ 245,000	$ 249,900	$ 254,898	$ 259,996						
Grants (note 3)	$ 1,565,050	$ 1,694,569	$ 686,505	$ 317,000	$ 224,000						
Gov. Contract (note 4)	$ 3,584,687	$ 5,493,800	$ 5,692,500	$ 5,787,000	$ 5,885,000						
Gov. Contract (note 4)- release of deferred revenue	$ 4,308,143										
Program Fees (note 5)	$ 416,953	$ 454,700	$ 468,341	$ 399,991	$ 411,991						
Total Revenue	**$18,138,111**	**$ 16,541,169**	**$ 16,372,550**	**$ 16,875,539**	**$ 17,437,552**	**$16,372,550**	**$17,600,000**	**$16,875,539**	**$17,970,000**	**$17,437,552**	**$18,520,000**
rev enhancements						$0	$1,227,450	$0	$1,094,461	$0	$1,082,448
Expenses:											
Personnel (note 6), incl manager of innov	$ 7,016,785	$ 8,090,000	$ 8,700,000	$ 9,048,000	$ 9,409,920						
Consultants/Subcontractors, non-contract (note 7)	$ 652,512	$ 655,000	$ 674,650	$ 694,890	$ 715,736						
Operations (note 8)	$ 656,900	$ 1,014,500	$ 1,044,935	$ 1,076,283	$ 1,108,572						
Rent (new space in 2016 for 20ksf @ $70 psf) (note 9)	$ 702,581	$ 733,800	$ 777,300	$ 1,400,000	$ 1,456,000						
Rent abatement (8 mos)-amortized over 10 yrs	$ -			$ (86,154)	$ (86,154)						
Grants/contracts, non-personnel (note 10)	$ 1,301,276	$ 2,527,646	$ 2,067,864	$ 1,812,700	$ 1,772,700						
Research, TC & Fellows, non-personnel (note 11)	$ 315,450	$ 457,800	$ 471,534	$ 485,680	$ 500,250						
Policy/Advocacy/Comms (note 11)	$ 764,040	$ 1,010,200	$ 1,040,507	$ 1,071,722	$ 1,103,874						
Mem Svc/Events (note 11)	$ 647,562	$ 842,600	$ 887,878	$ 914,514	$ 941,950						
Rebranding	$ 166,322	$ 100,000	$ 100,000	$ -	$ -						
Project Development	$ -	$ 200,000	$ 200,000	$ 200,000	$ 200,000						
Total Expenses, excl office move	**$12,223,428**	**$ 15,631,546**	**$ 15,964,668**	**$ 16,617,635**	**$ 17,122,848**						
Net surplus/(loss) before space buildout & move	**$5,914,683 32.61%**	**$ 909,623 5.50%**	**$ 407,882 2.49%**	**$ 257,904 1.53%**	**$ 314,704 1.80%**						
Office build-out and office relocation expenses:											
Amortization of space buildout			$ 53,988	$ 53,988	$ 53,988						
Depreciation on new furniture and telephones			$ 399,667	$ 399,667	$ 399,667						
Signage/Office movers/consultants		$ 212,000	$ 281,380	$ -							
Office move related expenses	**$ -**	**$ 212,000**	**$ 735,034**	**$ 453,654**	**$ 453,654**						
Total Expenses, including office move	**$ 12,223,428**	**$ 15,843,546**	**$ 16,699,702**	**$ 17,071,289**	**$ 17,576,502**	**$15,550,000**	**$16,699,702**	**$16,025,000**	**$17,071,289**	**$16,550,000**	**$17,576,502**
exp reductions						($1,149,702)	$0	($1,046,289)	$0	($1,026,502)	$0
Net surplus/(loss) after space buildout & move	**$ 5,914,683 32.61%**	**$ 697,623 4.22%**	**$ (327,152) -2.00%**	**$ (195,750) -1.16%**	**$ (138,950) -0.80%**	**$822,550 5.02%**	**$900,298 5.12%**	**$850,539 5.04%**	**$898,711 5.00%**	**$887,552 5.09%**	**$943,498 5.09%**
Profit Margin Goal		$623 5.00%	5.00%	5.00%	5.00%						

Expense Reductions on expenses necessary for 5% profit margin:

2015	($1,149,702)	-7%
2016	($1,046,289)	-6%
2017	($1,026,502)	-6%

AMERICA'S ESSENTIAL HOSPITALS

DATE March 24, 2014
TO Board of Directors
FROM David Lopez
RE Investment, Audit & Compliance Committee Update

MEMORANDUM

On behalf of the America's Essential Hospitals investment and audit and compliance committee ("committee"), I am writing this memo to update you on the committee's activities since our last formal report.

The committee met by telephone January 13 to review the association's investment portfolio with Paul Shea, investment adviser; discuss the audit scope with Amy Boland, CPA, audit partner at Gelman, Rosenberg & Freedman (GRF); and discuss a request for proposal (RFP) for a replacement investment adviser.

The reserve and intermediate funds within the association's portfolio totaled $3.4 million as of December 31. This is in addition to $1.8 million in certificates of deposits (CDs) and bonds. The CDs and bonds are not included in the reserve and intermediate fund portfolio because they are held in stable liquid assets should they be needed to fund operations.

The intermediate fund, constituting 56 percent of the investment portfolio, had $1.91 million invested in global equity funds and short-term and intermediate fixed income funds. The fund portfolio returned 5.2 percent for the year due to the nature of these conservative investments. The reserve fund, with a longer time horizon, had $1.49 million as of December 31 and has a more aggressive approach than the intermediate fund. This fund portfolio returned almost 28 percent for the year. Because the BlackRock Equity Dividend fund has lagged in performance the past few quarters, Shea will recommend a replacement fund for the committee's review.

The 2013 audit scope was reviewed with Boland and Caroline Cheney, audit manager. Their audit fieldwork began February 24 and is now completed. This is Boland's first year as the organizations' audit partner; the previous partner was rotated off the engagement after six years. The committee was comfortable with the audit scope and will be reviewing and discussing the draft financial statements with the auditors in April.

At the recommendation of Chief Financial Officer Rhonda Gold, the committee reviewed an RFP to replace Shea with a new investment adviser. Given the organizations' growth and complexity, the committee agreed it is time to hire a new investment adviser with a fresh perspective. The committee will review responses to the RFP and interview candidates. We will keep you informed of the selection once a decision is finalized.

AMERICA'S ESSENTIAL HOSPITALS

GELMAN, ROSENBERG & FREEDMAN
CERTIFIED PUBLIC ACCOUNTANTS

February 19, 2014

To the Board of Directors
America's Essential Hospitals
Washington, D.C.

We are engaged to audit the financial statements of America's Essential Hospitals (AEH) for the year ended December 31, 2013. Professional standards require that we provide you with the following information related to our audit. If you have any questions or concerns regarding your audit, please feel free to contact us and we can arrange a meeting or conference call to discuss this information in further detail.

Our Responsibility under U.S. Generally Accepted Auditing Standards

As stated in our engagement letter dated January 29, 2014, our responsibility, as described by professional standards, is to express an opinion about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles. Our audit of the financial statements does not relieve you or management of your responsibilities.

Our responsibility is to plan and perform the audit to obtain reasonable, but not absolute, assurance that the financial statements are free of material misstatement. As part of our audit, we considered the internal controls of AEH. Such considerations were solely for the purpose of determining our audit procedures and not to provide any assurance concerning such internal control. We are responsible for communicating significant matters related to the audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures specifically to identify such matters. We are also responsible for communicating particular matters required by law, regulation, agreement or other requirements applicable to the engagement.

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MEMBER OF THE AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS' PRIVATE COMPANIES PRACTICE SECTION

Planned Scope and Timing of the Audit

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested.

Our audit will include obtaining an understanding of AEH and its environment, including internal control, sufficient to assess the risks of material misstatement of the financial statements and to design the nature, timing, and extent of further audit procedures. Material misstatements may result from (1) errors, (2) fraudulent financial reporting, (3) misappropriation of assets, or (4) violations of laws or governmental regulations that are attributable to the entity or to acts by management or employees acting on behalf of AEH. We will generally communicate our significant findings at the conclusion of the audit. However, some matters could be communicated sooner, particularly if significant difficulties are encountered during the audit where assistance is needed to overcome the difficulties or if the difficulties may lead to a modified opinion. We will also communicate any internal control related matters that are required to be communicated under professional standards.

We expect to begin our audit on February 24, 2014 and complete your audit and information returns and issue at the conclusion of the audit and tax process.

This information is intended solely for the use of the Board of Directors and management of America's Essential Hospitals and is not intended to be, and should not be, used by anyone other than these specified parties.

Gelman Rosenberg & Freedman

February 19, 2014

AMERICA'S ESSENTIAL HOSPITALS

GELMAN, ROSENBERG & FREEDMAN
CERTIFIED PUBLIC ACCOUNTANTS

January 29, 2014

Ms. Rhonda Gold
Assistant Vice President for Financial Operations
America's Essential Hospitals
1301 Pennsylvania Avenue, N.W.
Suite 950
Washington, D.C. 20004

Dear Ms. Gold:

We are pleased to confirm our understanding of the services we are to provide for America's Essential Hospitals for the year ended December 31, 2013.

We will audit the statement of financial position of America's Essential Hospitals as of December 31, 2013, and the related statements of activities and change in net assets, functional expenses and cash flows for the year then ended.

We will also prepare America's Essential Hospitals' Federal Form 990, Return of Organization Exempt from Income Tax, for the year ended December 31, 2013 and the D.C. personal property return.

Audit Objective

The objective of our audit is the expression of an opinion about whether your financial statements are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles. Our audit will be conducted in accordance with U.S. generally accepted auditing standards and will include tests of your accounting records and other procedures we consider necessary to enable us to express such an opinion. If our opinion is other than unqualified, we will discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit or are unable to form or have not formed an opinion, we may decline to express an opinion or to issue a report as a result of this engagement.

Audit Procedures

Our procedures will include tests of documentary evidence supporting the transactions recorded in the accounts, tests of the physical existence of inventories and direct confirmation of receivables and certain assets and liabilities by correspondence with selected individuals, funding

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sources, creditors, and financial institutions as deemed necessary. We will also request written representations from your attorneys as part of the engagement, and they may bill you for responding to this inquiry. At the conclusion of our audit, we will require certain written representations from you about the financial statements and related matters.

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements. We will plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether from (a) errors, (b) fraudulent financial reporting, (c) misappropriation of assets, or (d) violations of laws or governmental regulations that are attributable to the organization or to acts by management or employees acting on behalf of the organization.

Because of the inherent limitations of an audit, combined with the inherent limitations of internal control, and because we will not perform a detailed examination of all transactions, there is a risk that material misstatements may exist and not be detected by us, even though the audit is properly planned and performed in accordance with U.S. generally accepted auditing standards. In addition, an audit is not designed to detect immaterial misstatements or violations of laws or governmental regulations that do not have a direct and material effect on the financial statements. However, we will inform the appropriate level of management of any material errors and any fraudulent financial reporting or misappropriation of assets that come to our attention. We will also inform the appropriate level of management of any violations of laws or governmental regulations that come to our attention, unless clearly inconsequential. Our responsibility as auditors is limited to the period covered by our audit and does not extend to any later periods for which we are not engaged as auditors.

Our audit will include obtaining an understanding of the organization and its environment, including internal control, sufficient to assess the risks of material misstatement of the financial statements and to design the nature, timing, and extent of further audit procedures. An audit is not designed to provide assurance on internal control or to identify deficiencies in internal control. However, during the audit, we will communicate to you and those charged with governance internal control related matters that are required to be communicated under professional standards.

We may from time to time, and depending on the circumstances, use third-party service providers in serving your account. We may share confidential information about you with these service providers, but remain committed to maintaining the confidentiality and security of your information. Accordingly, we maintain internal policies, procedures, and safeguards to protect the confidentiality of your personal information. In addition, we will secure confidentiality agreements with all service providers to maintain the confidentiality of your information and we will take reasonable precautions to determine that they have appropriate procedures in place to prevent the unauthorized release of your confidential information to others. In the event that we are unable to secure an appropriate confidentiality agreement, you will be asked to provide your consent prior to the sharing of your confidential information with the third-party service provider. Furthermore, we will remain responsible for the work provided by any such third-party service providers.

Management Responsibilities

You are responsible for making all management decisions and performing all management functions; for designating an individual with suitable skill, knowledge, or experience to oversee the tax services and any other nonattest services we provide; and for evaluating the adequacy and results of those services and accepting responsibility for them.

You are responsible for establishing and maintaining internal controls, including monitoring ongoing activities; for the selection and application of accounting principles; and for the fair presentation in the statements of financial position, changes in net assets and cash flows in conformity with U.S. generally accepted accounting principles. You are also responsible for making all financial records and related information available to us and for the accuracy and completeness of that information. You are also responsible for providing us with (a) access to all information of which you are aware that is relevant to the preparation and fair presentation of the financial statements, (b) additional information that we may request for the purpose of the audit, and (c) unrestricted access to persons within the organization from whom we determine it necessary to obtain audit evidence. Your responsibilities include adjusting the financial statements to correct material misstatements and confirming to us in the management representation letter that the effects of any uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

You are responsible for the design and implementation of programs and controls to prevent and detect fraud, and for informing us about all known or suspected fraud affecting the organization involving (a) management, (b) employees who have significant roles in internal control, and (c) others where the fraud could have a material effect on the financial statements. Your responsibilities include informing us of your knowledge of any allegations of fraud or suspected fraud affecting the organization received in communications from employees, former employees, grantors, regulators, or others. In addition, you are responsible for identifying and ensuring the organization complies with applicable laws and regulations.

With regard to the electronic dissemination of audited financial statements, including financial statements published electronically on your website, you understand that electronic sites are a means to distribute information and, therefore, we are not required to read the information contained in these sites or to consider the consistency of other information in the electronic site with the original document.

You are required to disclose in the financial statements the date through which subsequent events have been evaluated and that date is the date the financial statements were issued versus the available date to be issued. You agree that you will not date the subsequent event note earlier than the date of the management representation letter.

Engagement Administration, Fees and Other

We understand that your employees will prepare all confirmations we request and will locate any documents selected by us for testing.

Amy Boland is the engagement partner and is responsible for supervising the engagement and signing the report or authorizing another individual to sign it. We expect to begin our audit at a mutually agreed upon date. We will issue our audit report and the information return(s) at the conclusion of the audit and tax process.

We estimate that our fee for these services will be $24,150. We will bill you only for the time expended, plus out-of-pocket costs such as travel, report production, typing, postage, etc. Additional expenses are estimated to be $500. The fee estimate is based on anticipated cooperation from your personnel and the assumption that unexpected circumstances will not be encountered during the audit. Our invoices will be rendered each month as work progresses and are payable on presentation. If we elect to terminate our services for nonpayment, our engagement will be deemed to have been completed upon written notification of termination, even if we have not completed our report. You will be obligated to compensate us for all time expended and to reimburse us for all out-of-pocket expenditures through the date of termination.

We appreciate the opportunity to be of service to you and believe this letter accurately summarizes the significant terms of our engagement. If you have any questions, please let us know. If you agree with the terms of our engagement as described in this letter, please sign and return it to us.

Sincerely,

GELMAN, ROSENBERG & FREEDMAN

Amy Boland

Amy Boland
Certified Public Accountant

RESPONSE:

This letter correctly sets forth the understanding of America's Essential Hospitals.

Officer Signature

CEO

Title

2/4/14

Date