



AMERICA'S ESSENTIAL HOSPITALS

Board of Directors Orientation Booklet

2015 - 2016



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Proposed America's Essential Hospitals Board of Directors 2015–2016

CHAIR

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

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

CHAIR-ELECT

John Haupert
President and CEO
Grady Health System

Wright Lassiter III (2015–2017)
President
Henry Ford Health System

PAST-CHAIR

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

Carlos Migoya (2015–2017)
President & CEO
Jackson Health System

SECRETARY

Michael Karpf, MD
Executive Vice President for Health Affairs
UK HealthCare

Sharon O'Keefe (2015–2017)
President
University of Chicago Medicine

TREASURER

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

Ramanathan Raju, MD, MBA (2015–2017)
President and CEO
New York City Health and Hospitals Corporation

AT-LARGE DIRECTORS

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

Sheldon Retchin, MD, MS, MSP (2014–2016)
Executive Vice President of Health Sciences, CEO
The Ohio State University Wexner Medical Center

Akram Boutros, MD (2015–2017)
President and CEO
The MetroHealth System

Sam Ross, MD, MS (2015–2017)
CEO
Bon Secours Baltimore Health System

Timothy M. Goldfarb (2014–2016)
EVP, for Regional & Governmental Affairs
UF Shands HealthCare

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

Stan Hammack (2015–2017)
CEO
University of South Alabama Medical Center

EX OFFICIO
Irene M. Thompson
President and CEO
UHC



2015 – 2016 Association Board Meeting Dates

Tuesday, June 23, 2015

11 am – 5 pm

Westin Gaslamp Quarter

San Diego, CA

Held in conjunction with June 24–26, 2015, VITAL2015

Monday, October 26, 2015

11 am – 5 pm

Hyatt Regency Washington on Capitol Hill

Washington, DC

Held in conjunction with October 27-28, 2015, Policy Assembly

December 2015 conference call – TBD

Monday, March 7, 2016

11 am – 5 pm

Hyatt Regency Washington on Capitol Hill

Washington, DC

Held in conjunction with March 8-9, 2016, Policy Assembly

Tuesday, June 14, 2016

11 am – 5 pm

Seaport Hotel

Boston, MA

Held in conjunction with June 15–17, 2016, VITAL2016

October 2016 – TBD

December 2016 conference call - TBD



**America's Essential Hospitals/Essential Hospitals Institute
Volunteer Travel Policy
2015 Board Meetings**

Because America's Essential Hospitals is a not-for-profit organization, volunteer leaders are asked keep this in mind when they make their travel arrangements which are reimbursed by the association.

In general, America's Essential Hospitals/Essential Hospitals Institute will reimburse the following expenses: economy class airfare/train, hotel room and tax, meals, and ground transportation. We will NOT reimburse for dry cleaning/laundry service, movies/ entertainment or fitness center fees.

HOTEL _____

Hotel Accommodations

America's Essential Hospitals will pay for up to three (3) nights (room and tax only) on our master account for Vital2015 and up to two (2) nights for the Spring and Fall Board Meetings.

Hotel Reservations

1. For each meeting, volunteers will be provided directions for making their hotel reservations and encouraged to complete them as soon as possible. Regardless of the length of your stay, association staff will make arrangements for billing the number of nights outlined above to the Association's Master Account. Additional nights will be your responsibility.
2. All incidentals will be charged to the volunteer's personal charge card, which should be provided to the hotel upon check-in.
3. If a cancellation is necessary, the volunteer's office is responsible for contacting America's Essential Hospitals at least three days prior to the meeting. Otherwise, the volunteer's organization will be responsible for any room charges America's Essential Hospitals/Essential Hospitals Institute may incur.
4. Early reservations are encouraged in order to assure availability at the conference hotel.

AIR/GROUND TRANSPORTATION _____

Up to \$1,000 is allowed for airfare (or train) and ground transportation expenses. This allowance is based on booking economy class tickets. Travel plans that exceed this amount must be cleared with Association staff in advance of completing your reservation. Mileage for use of personal cars will be reimbursed at the current IRS rate in effect at the time of the travel.

Transportation Reservations

Airfare, train, car rentals and/or shuttle reservations are made directly by the volunteer's office.

MEALS

During the conference period, volunteer members are reimbursed for meals not covered by the meeting.

REIMBURSEMENT

Within 30 days of volunteer's return from travel, an America's Essential Hospitals/Essential Hospitals Institute Travel Expense Report must be submitted to the Association for reimbursement. Because IRS regulations require that all expense reimbursements be substantiated, itemized receipts must be attached to the Travel Expense Form and signed by the originator. This form should be e-mailed to the attention of the Senior Manager of Meetings and Events The Association will reimburse travel expenses within two weeks of receiving the Travel Expense Form. Regretfully, we will not reimburse for expenses received more than 30 days from travel.



Association Board of Directors Meeting
March 16, 2015
11 am – 5 pm ET
Agenda

11 – 11:05 am	Call to Order and Disclose Conflicts of Interest (Walker)	
11:05 – 11:10 am	Approve Consent Agenda (Walker) • December 2014 minutes • New members	ACTION
11:10 – 11:25 am	President's Report (Siegel)	
11:25 – 11:30 am	Review and Approve Institute Board Nominations (Walker)	ACTION
11:30 – 11:35 am	Nominating Committee Report (Spisso)	
11:35 – 11:50 am	Revised UHC Memorandum of Understanding (Siegel)	ACTION
11:50 am – 12:15 pm	Board Member Expectations (Walker)	ACTION
12:15 – 12:45 pm	Lunch	
12:45 – 1:45 pm	Membership Committee Report: Member Satisfaction Survey Results (McKinley Advisors)	
1:45 – 3 pm	Policy/Advocacy Update (Feldpush)	
3 – 3:15 pm	Break	
3:15 – 3:30 pm	Education Committee Report (Belzer)	
3:30-3:45 pm	Strategic Planning Committee Report (Karpf)	
3:45 – 4:15 pm	Essential Hospitals Institute Update (Engler)	
4:15 – 4:30 pm	Office Move and Financial Update (Gold)	ACTION
4:30 pm	Adjourn	
4:30 – 5 pm	Executive Session	



Board of Directors Meeting
Monday, December 1, 2014
Meeting by Telephone

Board Members Present (13)	Board Members Absent (5)	Staff Present (7)
Reginald W. Coopwood, MD Timothy M. Goldfarb John M. Haupert George Hernandez Jr., JD Michael Karpf, MD Wright L. Lassiter III Sharon O'Keefe Ramanathan Raju, MD, MBA Sheldon Retchin, MD, MSPH Donna K. Sollenberger, MA Roxane A. Townsend, MD Thomas P. Traylor, MBA William B. Walker, MD	Michael B. Belzer, MD Steven G. Gabbe, MD Santiago Muñoz III Johnese M. Spisso, MPA, RN Irene M. Thompson	Bruce Siegel, MD, MPH David Engler, PhD Beth Feldpush, DrPH Rhonda Gold Kristine Metter Jummy Siwajuola Caitlyn Furr

Agenda Item	Minutes
Call to order (Walker)	<ul style="list-style-type: none">Walker called the meeting to order at 11:02 am.
Approve Consent Agenda (Walker)	Members reviewed the October 28 meeting minutes. <i>Walker requested a motion to approve the consent agenda. There was a motion, a second, and unanimous approval of the consent agenda.</i>
Review and Approve 2015 Proposed Budget (Coopwood/Gold)	<ul style="list-style-type: none">Gold reported that the 2015 proposed budget was approved by the finance committee on November 21, and budgeted activities support the 2013-2018 strategic plan.Budgeted 2015 revenue is \$10.2 million, an increase of 15 percent (or \$1.3 million) from the 2014 projection and 18 percent more (or \$1.5 million) than the 2014 budget.The largest increase is in membership dues. The 2015 budget assumes six new members. The bad debt line reflects the deactivation of four

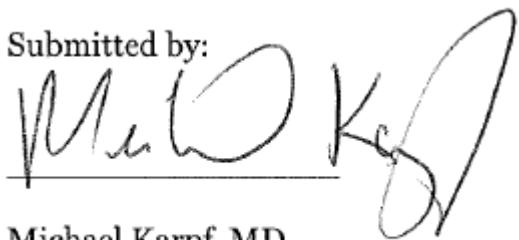
	<p>members (totaling \$266,000) as a result of the new dues structure. The 2015 membership dues invoices reflecting the new tiered dues structure were sent to members at the beginning of November.</p> <ul style="list-style-type: none"> Budgeted dues are \$1.23 million (or 23 percent) more than the 2014 projected level. Of that increase, \$285,000 is based on new 2014 members paying full-year dues in 2015, \$252,500 represents new 2015 member recruits, and \$128,000 stems from reclassification of memberships to different membership categories. In addition, \$568,000 comes from the change in dues structure. The new corporate affiliate member category (approved at the October 28 board meeting) created the need to reclassify \$80,000 from the sponsorship line, into the membership category. Budgeted sponsorship revenue is \$200,000. The 2015 budget reflects \$260,000 for conference registration fees, of which \$151,000 is for VITAL2015 and \$34,000 is for registration fees for an in-person waiver meeting. The conference registration line is substantially higher than 2014 (by 55 percent) because the Government Relations Academy occurs every other year. Total budgeted expenses for 2015 is \$8.8 million, of which \$4.4 million is in association salaries and fringes, an increase of 8 percent from the 2014 budget. This includes the addition of three new budgeted positions. Health insurance increases of 25 percent recently assessed by Carefirst are substantially higher than 2014 and prior years. This is because the association was classified in the under 50 employees market which is not competitively priced in the marketplace. Budgeted expenses also include a \$595,000 contribution to the Institute to support research and analytics work that is not externally funded. Because Kaiser Permanente's three-year grant to support the Transformation Center ended in 2014, core support from membership dues is once again necessary to continue the Institute's important research and analytical work in support of the membership. Without this funding, the Institute's budgeted operating deficit would be \$672,000 (versus a budgeted \$80,000 deficit, the same budgeted level as in 2014). The policy line reflects \$294,000 in budgeted expenses, an increase of \$26,000 (or 10 percent) from the 2014 projected level and 19 percent more than the 2014 budget. The increase in budgeted costs is primarily due to outsourcing of sophisticated quantitative analysis and analytical modeling to KNG Health and The Moran Company (for \$190,000). The increase in this line item recognizes an expected need for analysis of regulatory and legislative proposals. The advocacy line reflects \$653,000 in budgeted expenses, an increase of 43 percent from the 2014 budget. It includes the hosting of two policy assembly events (\$244,000); Holland & Knight LLP retainer fees (\$156,000) for general advocacy services; Schrayer and Associates
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	<p>consulting services (\$40,000); site visits and outside meetings (\$27,000); and dues, subscriptions, licenses, and webinars (\$43,000).</p> <ul style="list-style-type: none"> • The budget for conferences reflects a 40 percent from the 2014 projected amount and 4 percent increase from the 2014 budget. VITAL2015 will be held in San Diego, which is a more expensive location. • Member services is budgeted at the same level as 2014 and reflects site visits for membership recruitment and retention activities, awards and education committee expenses, membership materials and mailings, sponsorships to other organizations, and conference site visit travel. • The communications line was reduced by 25 percent from the 2014 budget because of the reclassification of \$50,000 for the Coalition to Protect America's Healthcare to the advocacy line. • Consulting is budgeted at \$117,500, which is a decrease from 2014. The amount budgeted for the retainer has also decreased from 2014, as the association is making efforts to scale back its use of Eyman Associates and utilize internal staff instead. • Rent is budgeted at \$385,000, which is a 2 percent increase from the 2014 projected amount. This amount does not include rent for the new space, as the association will move in December 2015. • Travel and professional development is budgeted at \$180,000. This is an increase of 41 percent due to increased staff professional development opportunities to include continuing education and professional certification classes, new staff training initiatives, a site visit to a member hospital, licenses for online professional development videos, and budgeted training opportunities as recommended by the leadership team. The association has created an internal staff committee on professional development to encourage staff development. • Taxes/insurance/miscellaneous is budgeted at \$87,000. The largest increase in this budget line is due to a higher line of credit bank fees as a result of the move. • Depreciation is budgeted at \$157,000, which is an increase of 108 percent from the 2014 budget. \$93,000 was reclassified into depreciation because the new website and branding are now an ongoing operational expense. • The 2015 budgeted operating surplus is \$1.4 million, before moving expenses (of \$435,000) funded from reserves, for a gain in net assets (surplus) of \$972,000. • Total budgeted net assets are \$9.45 million, of which \$450,000 is restricted for the office relocation in late 2015. This budgeted ending net asset balance of \$9.45 million represents almost one year of the association's operating expenses in reserves. <p><i>Walker requested a motion to approve the 2015 proposed budget. There was a motion, a second, and unanimous approval of the 2015 budget.</i></p>
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Policy Advisory Committee (Feldpush)	<ul style="list-style-type: none"> • Haupert directed the board to the draft principles on equity of care. • America's Essential Hospitals has not had an official position on equity of care. The association decided to create a set of guiding principles for members, for use when the association is asked about its stance on socioeconomic status (SES) and equity of care. • The policy advisory committee met three times by phone in the fall and drafted 11 principles. The committee began by stating that essential hospitals have a responsibility related to equity of care, and by reflecting on the definition of essential hospitals. • The board reviewed each of the principles aloud. • The third principle says that health care providers need to proactively assess the needs of their community in order to promote equity. Sollenberger commented that the language of the third principle gives the impression that hospitals would take the leadership role, but it is important for the communities to be engaged. She suggested rewording the principle to state that "health care providers will work proactively with communities to assess..." • O'Keefe asked if the committee considered the community benefits survey that hospitals are already required to perform. Feldpush replied that there are synergies that could be leveraged with existing assessments, but that the committee really wanted to highlight the importance of addressing disparities. • Principle 11 says that essential hospitals incur a disproportionate part of the cost of care and should receive reimbursement. Walker mentioned that this principle addresses SES factors that the association is approaching with National Quality Forum. Feldpush said that principle 10 also addresses SES. The committee discussed principle 10 as being a broad statement, but also felt that there should be specific language about payments. <p><i>Haupert requested a motion to approve the principles of care. There was a motion, a second, and unanimous approval of the principles of care.</i></p>
Advocacy Update (Feldpush)	<ul style="list-style-type: none"> • Feldpush gave a postelection update on the state of affairs in Washington. • Congress is back in session, which will be good for the December 8-9 Policy Assembly. • As expected, the Senate will be controlled by Republicans in January, and Republicans will continue to control the House. • Sen. Orrin Hatch, (R-UT), will chair the Senate Committee on Finance beginning in January. His staff has an aggressive agenda and would like to reopen some changes to the Medicaid program and the Affordable Care Act. There are no firm details at this point as to how the plan would work, or the budget implications. Hatch's staff has

	<p>also targeted the medical device tax, which is concerning from the hospital side because we would want to assure that no hospital funding is used to offset the cost of the device tax repeal. Hatch's staff has also discussed revising Medicaid with per capita caps.</p> <ul style="list-style-type: none"> • Rep. David Camp (R-MI) is retiring and Rep. Paul Ryan (R-WI) will become the new chair of the House Committee on Ways and Means. Ryan has specific health care ideas and is likely to look at per capita caps and entitlement program reforms. • In the short term, Camp put out a discussion draft of legislation that has a number of hospital-related items. The hospital package includes a payment policy for short-term inpatient stays, SES risk adjustment, and an end to the moratorium on physician-owned specialty hospitals. The association plans to encourage the delay of Medicaid disproportionate share hospital (DSH) cuts through 2017 in this legislation. • The administration has established readiness tiers for hospitals, but has done little else on Ebola preparation. • Sollenberger mentioned the expenses related to treating Ebola at the last board meeting. The University of Texas Medical Branch has been asked what it would take to have a working bio-containment facility. The hospital is creating a white paper that outlines what it takes to staff one Ebola patient. Sollenberger will share the white paper with Feldpush and the board. • Association staff have prepared messages for the Policy Assembly on protecting Medicaid payments, the importance of the 340B Drug Pricing Program, SES risk adjustment, and protecting Medicare payments
Adjourn (Walker)	<ul style="list-style-type: none"> • Walker adjourned the meeting at 12:05 pm.

Submitted by:



Michael Karpf, MD
Secretary



Board of Directors Meeting
October 28, 2014
Washington, DC

Board Members Present (14)	Board Members Absent (3)	Staff Present (12)
Michael B. Belzer, MD Reginald W. Coopwood, MD Steven G. Gabbe, MD Michael Karpf, MD Wright L. Lassiter III Johnese M. Spisso, MPA, RN Thomas P. Traylor, MBA William B. Walker, MD By phone: Timothy M. Goldfarb George Hernandez, Jr., JD Santiago Muñoz, III Sheldon Retchin, MD, MSPH Donna K. Sollenberger, MA Roxane A. Townsend, MD	John M. Haupert Ramanathan Raju, MD, MBA Irene M. Thompson	Bruce Siegel, MD, MPH David Engler, PhD Beth Feldpush, DrPH Rhonda Gold, CPA Kristine Metter, CAE Sarah Callahan, MHSA Carl Graziano Shawn Gremminger, MPP Xiaoyi Huang, JD Alan Burk Katie Zimmerman Caitlyn Furr

Agenda Item	Minutes
Call to Order and Disclosure of Conflicts of Interest (Walker)	<ul style="list-style-type: none">Walker called the meeting to order at 11 am and asked for conflicts of interest with the agenda; none was disclosed.
Approve Consent Agenda (Walker)	Members reviewed the June 24 meeting minutes. Walker requested a motion to approve the consent agenda. There was a motion, a second, and unanimous approval of the consent agenda.
President's report (Siegel)	<ul style="list-style-type: none">Siegel noted Ebola events have impacted many members, further demonstrating the essential role of member hospitals.Spisso mentioned that University of Washington School of Medicine is a designated Ebola treatment center.

	<ul style="list-style-type: none"> • Siegel reported on several association activities: <ul style="list-style-type: none"> ◦ Risk adjustment for socioeconomic status (SES) remains on the association's agenda, with legislation in both houses of Congress. ◦ The association added two new members, Interim LSU and Rhode Island Hospital; and lost University of Colorado. ◦ Based on briefings with members, the association has found widespread support for dues restructuring. ◦ The association will meet with Sen. Ron Wyden (D-OR) December 9 to discuss priorities for members of America's Essential Hospitals.
Nominating Committee Report (Spisso)	<ul style="list-style-type: none"> • The board was asked to appoint a new secretary to fill the vacancy created by David Lopez's departure from the board. Karpf was nominated to fill this position. <i>Walker requested a motion to appoint Karpf as the new secretary of the board of directors. There was a motion, a second, and unanimous approval of Karpf's appointment.</i> • The board was asked to appoint a new at-large director. University of Chicago Medicine President Sharon O'Keefe was nominated. <i>Walker requested a motion to appoint O'Keefe as the new at-large director. There was a motion, a second, and unanimous approval of O'Keefe's appointment.</i> • The board was asked to appoint a new member director for the Essential Hospitals Institute board. Dennis Keefe, president and CEO of Care New England Health System, was nominated. <i>Walker requested a motion to appoint Keefe as the member director of the Institute board of directors. There was a motion, a second, and unanimous approval of Keefe's appointment.</i>
Finance Committee Report (Coopwood)	<ul style="list-style-type: none"> • Coopwood asked Gold to present the financial update, Referencing materials in the board book, she reported these items: <ul style="list-style-type: none"> ◦ America's Essential Hospitals' 2014 projected revenue is \$8.9 million, which is offset by \$7.19 million in expenses, before items funded from reserves, leaving an operating surplus of \$1.72 million. ◦ The projected surplus is \$894,000 more than budget and \$700,000 better than last projected, in June. The increase is mostly a result of new membership dues. ◦ A summary of significant budget variances. <p><i>Gold stated that the finance committee approved and recommended that the board set aside an additional \$100,000 in board-restricted net assets to fund</i></p>

	<i>the non-depreciable and non-amortizable costs for the office move, for a total of \$450,000 in restricted net assets. There was a motion, a second, and unanimous approval.</i>
Office Relocation and Lease Terms (Gold)	<ul style="list-style-type: none"> • Gold provided a brief office move update and introduced DTZ representatives Aaron Pomerantz and Cathy Jones. • Jones credited America's Essential Hospitals' staff with having foresight to enlist DTZ's services early on, which provided enough time and leverage to negotiate a good deal. He noted that when the process began, the market was fairly soft, but began to tighten over time. • DTZ outlined the lease acquisition process: <ul style="list-style-type: none"> ◦ Gold, Burk (HR director) and IT Director Mark Campbell visited 12 of 35 potential buildings. The list was further narrowed to three finalist sites, which the leadership team toured. ◦ Characteristics considered included cost, location, access to public transportation, and space efficiency. ◦ The selected space, at 401 9 St. NW, is a 14-year-old Class A Gold LEED building with amenities, including a rooftop terrace, a fitness center, and retail in the area and in the building. The building is three blocks from the association's current location, closer to Capitol Hill, and convenient to two subway stations. ◦ America's Essential Hospitals will occupy the south side of the ninth floor under a 15-year lease. The team negotiated extensively and signed a lengthy, non-binding letter of intent with Boston Properties, the terms of which were shared with the finance committee. An attorney is reviewing the formal lease agreement. ◦ Architects determined the association needs approximately 21,100 square feet of office space, including a conference room large enough to accommodate board meetings and space to accommodate staff growth. ◦ In years 5 and 10, the organization will have a right to expand into 3,000 to 4,000 square feet of rentable contiguous space; however, if the first expansion option is not exercised, the second option will be forfeited. The association also has an ongoing first right of refusal to lease up to 5,000 square feet of space on the same floor, though this may not be contiguous space. The opportunity exists to sublease. ◦ The negotiated rental cost, rent abatement, and tenant improvement allowance is more favorable than the real estate brokers' original estimate and substantially better than the assumptions previously communicated to the board.

- The negotiated rent is \$67.25 per square foot (inclusive of operating expenses) with 14 months of free rent abatements, 2.5 percent annual rent increase, and a \$115 per square foot allowance for tenant improvement.
 - Staff's original estimates assumed a rental cost of \$70 per square foot for 20,000 square feet, an \$85 to \$95 per square foot tenant improvement allowance, and eight months of rent abatements. The rent abatement, which equates to a 7 percent to 8 percent cost reduction, can be converted to an additional tenant improvement allowance.
 - A four-month security deposit (approximately \$483,400) is required in the form of an irrevocable letter of credit, reducing over time, with only one month's deposit remaining after Year 4, assuming the association's revenues are at least \$8.5 million a year.
 - The lease will be in the name of the association only, as its revenue stream is (1) more consistent and reliable than the Institute's revenues based on grant and contract receipts; and (2) having two entities as co-tenants on a lease makes each entity jointly and severally liable for the entire amount of tenant obligations.
 - A financial analysis prepared by DTZ estimates annual rent of more than \$1.4 million, which will escalate by 2.5 percent per year in base rent plus operating expenses. The total cost over 15 years is estimated at \$25 million.
 - The total office move budget, including the office build-out, audiovisual, furniture, equipment, and artwork, is estimated at \$4.3 million, of which \$2.4 million will come from the tenant improvement allowance, for a net cost of approximately \$1.9 million (staff previously estimated a net cost of \$2.3 million).
 - Traylor asked how many more FTEs we could fit in the new space.
 - Gold responded that the new space will accommodate 70 employees, and staff total is now 58. There is some room for immediate growth plus the two expansion options for contiguous space in years 5 and 10.
 - Siegel mentioned that the association did not want to take more space than needed, despite its accelerated growth.
 - Gabbe said staff was sensitive to finding space consistent with the association's mission and that the choice is "A" space, but not "trophy" space.
 - Gold stated that the finance committee recommends approval of the terms, which would allow Siegel to enter into a binding contract in accordance with the terms of the non-binding letter of intent. All questions were addressed.
- Walker asked for a motion to provide board authorization for Siegel to enter into a formal lease agreement with Boston Properties for 401 9 St. NW,*

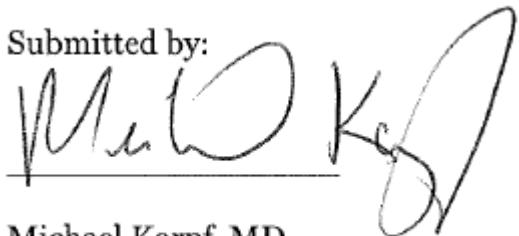
	<i>assuming the lease terms do not differ in any significant way from the letter of intent. There was a motion, a second, and unanimous approval.</i>
Membership Committee Report (Traylor)	<ul style="list-style-type: none"> • Traylor requested approval for a proposal to establish a corporate affiliate membership category. The membership committee vetted the proposal and recommended its approval. • America's Essential Hospitals now has two membership categories: full members and associate members. The association's bylaws allow for a corporate affiliate membership category to be created. The new category would allow vendors to work with the association on a more consistent, year-round basis. • There are \$5,000 per year or \$15,000 per year options for this membership category. • The association would not allow alcohol, gambling, firearms, or tobacco vendors to join, and corporate affiliates would be asked to sign a code of ethics. • Belzer asked for a census of associate members. Metter pointed to Central Health, in Texas, only, an indication the association is not likely to have a large number of associate members. <p><i>Traylor asked for a motion to approve the creation of a corporate affiliate membership category. There was a motion, a second, and unanimous approval of the category.</i></p>
Board Member Expectations: Initial Discussion (Walker)	<ul style="list-style-type: none"> • Walker and Siegel believe it would be beneficial to create clear expectations for board participation. • The expectations suggested include: informally helping to recruit and retain members; attend meetings; serve on committees; and encourage their hospital staff's involvement with the association. • They will create a formal set of expectations for use in assessing members' level of engagement against such expectations during reappointment. • Traylor mentioned political engagement with local representatives. Advocacy expectations would be good for potential board members to know up front. • Siegel said that the board would revisit expectations at its March 2015 meeting.
Education Committee Report (Belzer)	<ul style="list-style-type: none"> • The committee met in September at the association's offices and agreed that educational programs should be interactive. • The 2015 education programming will focus on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Delivery System Reform Incentive Payment (DSRIP) Program waivers, and behavioral health. • The current Fellows Program class has gone through two sessions. This year's theme is adaptive leadership. Applications for the next class of

	<p>fellows will open in December and close in February, and repeat the theme of adaptive leadership.</p> <ul style="list-style-type: none"> • The association opened a call for proposals for VITAL2015 presentations. Belzer asked board members to encourage colleagues to apply. The education committee will meet in December to review the proposals. • The association is developing an Essential Women’s Leadership Academy mentoring and networking program for women. It is expected to begin in late 2015 or early 2016.
Policy Advisory Committee Report (Haupert)	<ul style="list-style-type: none"> • Feldpush presented the report in Haupert’s absence. • The group is actively drafting principles around equity of care and reducing disparities to present to the board in December • Retchin asked if the principles address data on risk adjustment for readmissions rates. Feldpush said the principles address equity more broadly, but noted that the association supports risk adjustment of certain quality measures for patient SES status. Siegel said the board discussed risk adjustment at the last meeting, and America’s Essential Hospitals has been vocal and uncompromising on the issue.
Policy/Advocacy Update (Feldpush)	<ul style="list-style-type: none"> • Feldpush provided an overview of the upcoming midterm election landscape. • The nation has experienced a dramatic increase in political polarization, both among policymakers and Americans in general, during the past 20 years. • There will be 36 governor races in the general election, with Republican victories likely. • All U.S. House of Representatives seats are up for election, most of which are safe for incumbents. Republicans may pick up a few seats, and already have a solid majority, and will likely keep that majority until the next census. • In the U.S. Senate, 36 seats are in play. Republicans need to net six additional seats to take a majority in the Senate, which looks likely to happen. Looking at past midterm elections, the president’s party loses six seats, on average. Many of the races are close, and some are likely to go into runoffs. There is a possibility of three independents in the Senate, which could also tip the majority. • The opposite situation may occur in 2016. Republican seats will be open, providing momentum for a Republican president and a Democratic Senate. • Walker asked about the association’s strategy for a Republican Senate. • Feldpush said that the first order of business after the election is the lame-duck session, during which Congress needs to pass a continuing resolution to continue funding the government.

- Feldpush outlined a status update of legislative action important to the association:
 - Debt ceiling will come up in the spring, with the date uncertain, but hospital legislation may be attached.
 - Medicare sustainable growth rate (SGR) patch runs out in the spring. This is must-pass legislation, but momentum for a permanent fix has waned.
 - Children's Health Insurance Program (CHIP) reauthorization: Funding for CHIP expires September 30, 2015, so it will need to be addressed. The association is pushing for CHIP reauthorized this year because Sen. Orrin Hatch, (R-UT), who would become chair for the Senate Finance Committee, is developing some aggressive Medicaid reforms, and wants to attach them to the CHIP reauthorization legislation. The association is currently talking with his staff.
 - A plan created by Sens. Hatch, Richard Burr (R-NC), and Thomas Coburn (R-OK) would replace the Affordable Care Act (ACA) and alter Medicaid by making it a per-capita caps program. The association is providing feedback on the proposals, which lack detail.
- December 8 and 9 mark the association's next legislative fly-in. The lame-duck session will be a key time to talk about essential hospitals' concerns before the Hill tempo picks up in January.
- Issues at the forefront of the Hill discussions in December: the 340B Drug Pricing Program, risk adjustment, reducing disparities, CHIP reauthorization, Medicare disproportionate share hospital (DSH) payments, and the workforce. Of these, 340B will likely get more attention in the next Congress.
- Belzer asked about the association's strategy for reducing disparities.
- Feldpush responded that an idea is in development that would partner hospitals and the U.S. Department of Health and Human Services (HHS), with a focus on hospitals ready to accelerate work to reduce disparities. Under the plan, hospitals would get startup funding for creating programs to reduce disparities and ongoing funding as an incentive. Savings would accrue to the government because of better outcomes; those savings would pay for the program.
- The board discussed this concept and agreed that the degree to which hospitals are held accountable for a population's health will need to be carefully considered.
- Feldpush elaborated on the key issues facing Congress:
- 340B: Sources within the Health Resources and Services Administration (HRSA) indicate a decision is forthcoming on how to move forward on possible non-controversial provisions with

	<p>interpretive guidance. Congress will likely be more active on 340B in the next year. The Pharmaceutical Research and Manufacturers of America (PhRMA) is mounting an aggressive media campaign against 340B. However, the campaign is having little impact on independent thinkers. America's Essential Hospitals will try to reframe the issue: If Congress wants to scale back the program, it will take resources away from essential hospitals and increase costs to taxpayers.</p> <ul style="list-style-type: none"> • Ebola preparedness: The association has been in regular contact with the Centers for Disease Control and Prevention and HHS and has been pushing out information to members, including through a webpage dedicated to Ebola resources. • Feldpush said the association is getting questions from Congress about what hospitals need. The chief idea is to fully fund the Hospital Preparedness Program, which has been cut by 50 percent over the past decade. There will be an Ebola hearing by the Senate Appropriations Committee on November 12. • Sollenberger said The University of Texas Medical Branch (UTMB) is designated in Texas as an Ebola receiving hospital because Galveston National Lab is on its campus and studies emerging diseases, and the hospital has waste disposal facilities on site. UTMB calculated construction costs to build an Ebola isolation unit would be about \$2 million per bed. • Sollenberger will soon have a list of all costs for staffing, training, and building. • Karpf said the country needs to develop a coherent plan for containing outbreaks, as there are sure to be other emerging microbes after Ebola. • Spisso said hospitals need more funding for personal protective equipment. • Feldpush will reach out to board members individually before the hearings.
Executive Session	<ul style="list-style-type: none"> • The board went into executive session at 2:56 pm and the meeting was adjourned.

Submitted by:



Michael Karpf, MD
Secretary



Board of Directors Meeting
June 24, 2014
San Antonio, TX

Board Members Present (15)	Board Members Absent (4)	Staff Present (11)
Michael B. Belzer Reginald W. Coopwood, MD John M. Haupert George B. Hernandez Jr. Michael Karpf, MD David S. Lopez Stephen W. McKernan Santiago Muñoz Ramanathan Raju, MD, MBA Sheldon Retchin, MD, MS, MSP Donna K. Sollenberger, MA Roxane A. Townsend, MD Irene M. Thompson Thomas P. Traylor, MBA William B. Walker, MD	Steven G. Gabbe, MD Timothy M. Goldfarb, CEO Wright L. Lassiter III Johnese M. Spisso, MPA, RN	Bruce Siegel, MD, MPH David Engler, PhD Beth Feldpush, DrPH Rhonda Gold, CPA Kristine Metter, CAE Sarah Callahan, MHSA Carl Graziano Shawn Gremminger, MPP Xiaoyi Huang, JD Bianca Perez, PhD Sandy Laycox

Agenda Item	Minutes
Call to order and disclosure of conflicts of interest (Traylor)	<ul style="list-style-type: none">Traylor called the meeting to order at 11:10 am and asks for conflicts of interest; none disclosed.Retchin noted he is a director of a public company that provides post-acute care.
Welcome new board members (Traylor)	<ul style="list-style-type: none">Traylor welcomed new board members Raju, Haupert, Sollenberger, Lassiter, and Townsend.Traylor also recognized members leaving the board and those returning.
Approve consent agenda (Traylor)	<ul style="list-style-type: none">Members reviewed March 31 meeting minutes.

	<i>Traylor requested a motion to approve the consent agenda. There was a motion, a second, and unanimous approval of the consent agenda.</i>
President and CEO report (Siegel)	<ul style="list-style-type: none"> • Siegel noted appreciation of Traylor's leadership. • Siegel recognized four new members: Care New England, East Alabama Medical Center, University of Chicago Medical Center, University of Mississippi; noted efforts of existing members in recruiting the new members. • Siegel described work to document the history of the association and release at VITAL2014 of a history book and video. • Siegel reported on several policy activities: <ul style="list-style-type: none"> ◦ contacts with senior leadership of the U.S. Department of Health and Human Services (HHS), association's response to HHS request for anecdotes of network exclusion—including story from Grady Health—and desire by new Centers for Medicare & Medicaid administrator to work with America's Essential Hospitals ◦ increasing interest in adjusting performance measures by socioeconomic factors ◦ association support of member work and association education around Medicaid Section 1115 waivers, including association's September 29 summit in Chicago • Siegel recounted conversation to recast memorandum of understanding with UHC and to broaden work beyond UHC supply chain members. • Traylor pointed out value of education on waivers. <p><i>Traylor requested a motion to approve new members. There was a motion, a second, and unanimous approval.</i></p>
Employee Climate Assessment (Siegel)	<ul style="list-style-type: none"> • Siegel described survey of staff to assess work climate. • Siegel noted use of association's core values used as a foundation for the survey design. • Society for Human Resource Management (SHRM) conducted the survey. • Siegel described overall findings: relative to SHRM database of all employers, association's overall job satisfaction higher (81 percent versus 70 percent), but a little behind organizations of similar size. • Siegel discussed association strengths: the work itself, benefits, financial stability. • Survey revealed opportunities: career advancement, professional developments, communication with senior management, pay compared with local market. • Overall employee engagement found to be similar to that of other

	<p>organizations.</p> <ul style="list-style-type: none"> • Siegel described action plan: employee committee, lunch with senior leaders, brief presentations at all-staff meetings. • Sustainability—going green—important to staff; new office space will reflect this. • Traylor suggested use of members as staff mentors; Siegel agreed. • Feldpush noted planned site visit by advocacy and policy staff to Einstein Medical Center Philadelphia. • Haupert pointed out positive aspect of high staff satisfaction with management. • Traylor asked about differences in results between association and Essential Hospitals Institute; Siegel reported none significant. • Engler described work of inter-departmental staff work groups around collaboration, storytelling, communication. • Walker complimented Siegel for his efforts to solicit feedback. • Thompson noted opportunities to increase staff collaboration between association and UHC.
Treasurer's Report (Lopez)	<ul style="list-style-type: none"> • Lopez presented reports in board book, noted results of audit. • Lopez presented second action item: budget update. • Gold reported that association on target to meet budget. <p><i>Lopez requested a motion to approve audit. There was a motion, a second, and unanimous approval.</i></p> <p><i>Lopez requested a motion to approve budget update. There was a motion, a second, and unanimous approval.</i></p>
Education Committee Report (Belzer)	<ul style="list-style-type: none"> • Belzer described various aspects of committee's work, including these: <ul style="list-style-type: none"> ○ goal of broadening participation in educational activities beyond C-suite members ○ new session types at VITAL2014, including mini-sessions, Rapid-Fire sessions, interest groups, networking opportunities, and popularity of track structure ○ use of education committee members as session moderators and ambassadors for first-time attendees at VITAL2014 ○ new call for proposals for VITAL2015 and education committee proposal evaluation process ○ upcoming educational opportunities on waivers and start of Fellows Program sessions on adaptive leadership • Engler reported 34 fellows this year from 15 organizations. • Traylor recognized strongly positive feedback from past fellows and inquires about changes to the current year's program. • Engler described new use of education committee to refresh, renew

	curriculum; change to adaptive leadership; re-evaluation of fellows mix to broaden beyond clinical leaders.
Policy Advisory Committee Report (Walker)	<ul style="list-style-type: none"> • Walker described previous year's work to develop principles for entitlement reform and current effort on principles for Medicaid changes at the state level. • Walker noted desire to keep principles in mind as health care moves toward new world of alternative payments. • Feldpush noted need to educate members on alternative payment models as waivers spread. • Hernandez pointed out concern in Texas of funding shift from ambulatory to hospital inpatient and impact on systems with large outpatient networks. • Traylor noted need to acknowledge reality that Medicaid rates are lower than Medicare rates—a parity principle, perhaps. • Walker said that given wide variation in waiver design, principles are needed to establish common goals. • Lopez asked whether intragovernmental transfers were considered in principle development and noted need to make sure states have “skin in the game.” • Coopwood noted opportunity for the association to serve as a clearinghouse on waiver information; Feldpush said the association tracks updates on waivers monthly. • Hernandez suggested expressing values, as well as principles in the document. • Karpf suggested coordinating with similar American Hospital Association work on alternative payment models principles. • Feldpush summarized suggested changes: <ul style="list-style-type: none"> ○ make more explicit that Medicaid underpays ○ include distinction between ambulatory and inpatient and recognition that hospitals do more than inpatient—clinics, pharmacy ○ incorporate accountability into principles (skin in the game by other stakeholders) ○ expand on values • Munoz suggested gearing up to identify negative elements of alternative payment models and preparing to articulate concerns. <p><i>Walker requested a motion to approve the proposed principles with changes as summarized by Feldpush. There was a motion, a second, and unanimous approval.</i></p>
Membership Committee Report: New Dues Structure	<ul style="list-style-type: none"> • Lopez summarized significant discussion around dues structure, recognition of “no perfect solution,” and varying perspectives on

(Lopez)	<p>fairness.</p> <ul style="list-style-type: none"> • Siegel thanked Lopez for his leadership and discussed current dues structure. • Siegel noted current structure relatively unordered and a potential disincentive for membership, especially among smaller organizations. • Goals of new structure: dampen extreme swings, minimize changes, reflect size, help smaller hospitals, encourage inclusion of all hospitals in multihospital systems, compete on price. • Siegel described proposed methodology: expenses-based, tiered, phased in for those with increases. • Siegel pointed out that, now, some large, multihospital systems pay a single hospital rate and might resist change. • Hernandez asked whether expenses metric includes whole system, including managed care plan; Siegel says whole system, but not managed care plan. • Siegel described revenue projections and comparison of association's dues with other associations. He noted that market tests revealed a general understanding of need but questions about where increased revenue goes, concerns about driving out larger members. • Siegel described next steps: board vote, communications, and dues invoices. • Coopwood asked whether plan is budget neutral; Siegel responds that it is not budget neutral, includes wiggle room, and assumes loss of four members. • Retchin complimented board and staff for a careful, deliberative process, and recommended flexibility for the largest systems. <p><i>Lopez requested a motion to approve the new dues structure. There was a motion, a second, and unanimous approval.</i></p>
Policy/Advocacy Update (Feldpush)	<ul style="list-style-type: none"> • Feldpush provided overview of recent congressional activity, including actions to delay disproportionate share hospital (DSH) payment cuts and require reporting on DSH need. • Feldpush reported Republican Party swinging more conservative as reaction to rise of Tea Party. • Enrollment trends and uncompensated care are complex issues. Even as uncompensated care declines, Medicaid shortfalls might increase. Reports of coverage successes must be tempered by these realities—essential hospitals remain vulnerable to funding difficulties. • Traylor noted that Massachusetts experience might be a good case study for current issues and that statewide numbers don't necessarily apply to essential hospitals. For example, the uninsured rate is 1

- percent statewide, but 10 percent at Boston Medical Center.
- Siegel noted challenge of calibrating message and communicating that coverage expansion is playing out with great variation.
 - Raju pointed out that new Medicaid patients are very expensive because they haven't been getting care for years, so more costly despite new coverage.
 - Coopwood cautioned against losing benefits of expansion in financial message.
 - Traylor noted that bottom lines might look better, but DSH cuts haven't happened yet.
 - Karpf recommended national and state messaging, as financial impact of expansion on state budgets will come into play.
 - Raju warned about competition for safety net funding by hospitals not traditionally considered safety nets; Siegel said association's work on an essential hospital designation will be sensitive to this concern.
 - Lopez asked about likelihood of DSH payments ultimately being tied to performance; Feldpush said recent history shows performance increasingly part of discussions on funding streams.
 - Karpf noted need to emphasize continued funding for trauma, other high-acuity services.
 - Feldpush discussed evolving "1 plus 4" essential hospitals designation definition.
 - Conversation shifted to 340B.
 - Retchin characterized essential hospitals as victims of 340B abuses by other hospitals with respect to public perception.
 - Raju suggested association should not flatly oppose regulation, but should work to make 340B program better; Siegel noted association support of appropriate regulation.
 - Feldpush said association adamantly opposed to scaling back program, given its benefits to patients and taxpayers.
 - Walker asked about association's working relationship with Safety Net Hospitals for Pharmaceutical Access; Feldpush reported a good working relationship, but sensitivity to differences in stakeholders.
 - Feldpush moved to discussion of premium assistance.
 - Coopwood asked whether foundations may provide assistance; Huang responded that federal government might allow this.
 - Traylor predicted CMS will embrace premium assistance when it becomes clear people can't afford even federally subsidized premiums.
 - Feldpush continued with overview of socioeconomic status adjustment, Children's Health Insurance Program funding, workforce issues, the two-midnight rule, network adequacy, Medicaid payment parity, Medicaid waivers.

<p>Update on NQF Risk Adjustment (Engler)</p>	<ul style="list-style-type: none"> • Engler described National Quality Forum (NQF) work and recommendations on socioeconomic (SES) adjustment of performance measures and importance to association members. • Work, as required by CMS, included creation of expert panel in October 2013 to study pros and cons of SES adjustment. Panel include several association members: David Nerenz, PhD (Henry Ford Hospital), Nancy Garrett, PhD (Hennepin County Medical Center), and Nancy Sugg, MD, MPH (University of Washington). • About 30 risk-adjustment models exist and none is perfect. The current readmissions model explains only about 60 percent of variants in readmissions. • The NQF expert panel drafted a report in March, and opened it up to public comment in April. America's Essential Hospitals responded in support of the draft report and worked with members to respond. Overall, NQF received 160 comments, 140 of which were supportive of SES adjustment. • Association stance is that NQF should change its current policy to endorse performance measures used in accountability applications that risk adjust for both clinical and SES patient factors. • Traylor asked about CMS motivations to require this work. Engler pointed to growing concern about SES' effects on outcomes. Siegel noted concern about lack of alignment within CMS on SES adjustment. • NQF also recommended that performance measures should be stratified to identify disparities and that a standard set of measures and recommendations on their use should be developed. • Belzer asked about member hospitals responses. Engler said NQF received more than 30 comments from member hospitals and UHC. Feldpush added that hospitals previously non-active in policy work responded. • Engler said the literature supports the use of SES adjustment and that the association had published a list of literature on its website. A recent article in <i>Health Affairs</i> also explored the issue. • Engler noted opposition arguments that SES adjustment would mask disparities or lessen expectations for improvement. • Engler said next steps include a final expert panel report June 30, review by the NQF Consensus Standards Approval Committee, and a NQF board of directors final vote July 23. • Raju predicted CMS reluctance to adjust for SES because it would be a “slippery slope”—some stakeholders may ask for geographic adjustment, for example. He called on the association to have a leadership role in ongoing discussions. • Engler agreed about the role of the association to emphasize a scientific basis, supported by literature, for risk adjustment.
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	<ul style="list-style-type: none"> • Retchin pointed out the argument is more complex than SES adjustment—essential hospital face resource challenges that also factor into differences. • Coopwood asked about the goal. What should come out of this effort and how will it improve care of this population? • Engler said the end game should be a level playing field for performance metrics by accounting for differences in patient population. • Siegel pointed out that the NQF recommendation doesn't require use of a specific model or adjustment generally. He said that while many people agree on the value of SES adjustment, strong opposition exists in some quarters, particularly among consumer groups (a majority of NQF members) and that consensus is crucial. • Raju noted a scientific basis for adjustment is necessary; Siegel agreed strongly. • Lopez suggested that separate adjustments for emergency department admissions versus other types of admissions might be a useful approach; several members indicated support for considering this.
Investment Policy (Gold & Raffa Wealth Management)	<ul style="list-style-type: none"> • Gold described the association's request for proposal process to choose an investment adviser; she introduced Mark Murphy, with Raffa Wealth Management. • Murphy described company's work, which focuses on non-profit organizations with portfolios of \$3 million to \$5 million; the association falls within that range. • Murphy described a three-step onboarding process for new clients: review financials, conduct interviews, conduct survey. • Murphy provided an overview of investment recommendations. • Retchin asked about alternative investments; Murphy responded that high fees make alternatives unattractive. • Walker asked for Murphy's opinion on investing in index versus actively managed funds. Murphy indicated preference for a passive (index) investment strategy. • Murphy reviewed changes to investment policy. <p><i>Traylor requested a motion to accept revised investment policy statement. There was a motion, a second, and unanimous approval.</i></p>
Executive Session	The board went into executive session and the meeting was adjourned.



America's Essential Hospitals
Board of Directors Meeting Minutes
March 31, 2014

Board Members Present (13): <ul style="list-style-type: none">• Thomas Traylor – (Chair)• William Walker – (Chair-Elect)• Johnese Spisso – (Secretary)• David Lopez – (Treasurer)• Stephen McKernan – (Past Chair)• Betsey Bayless• Michael Belzer• Reginald Coopwood• Michael Karpf• Santiago Muñoz• Jorge Orozco• Sheldon Retchin• Irene Thompson – (Ex Officio)	Board Members Absent (3): <ul style="list-style-type: none">• Timothy Goldfarb• George Hernandez• Steven Gabbe	Staff Present (13): <ul style="list-style-type: none">• Bruce Siegel• Alan Burk• David Engler• Beth Feldpush• Rhonda Gold• Carl Graziano• Shawn Gremminger• Xiaoyi Huang• Kristine Metter• Katie Reid• Jummy Siwajuola• Kiran Sreenivas• Katherine Susman• Katie Zimmerman
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Agenda Items	Minutes
Call to Order and Disclose Conflicts of Interest (Traylor)	<ul style="list-style-type: none">• Call to order at 11:19 am• Request for conflicts of interest; none disclosed
Approve Consent Agenda (Traylor)	<ul style="list-style-type: none">• Approve December 2013 meeting minutes• Approve October 2013 meeting minutes• Approve new members<ul style="list-style-type: none">○ 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 <p><i>Traylor requested a motion to approve the consent agenda. There was a motion, a second, and unanimous approval of the consent agenda.</i></p>
President and CEO's Report (Siegel)	<ul style="list-style-type: none">• Two vice presidents have departed over the past several months, Jill Steinbruegge and Linda Cummings. This prompted leadership to assess the optimal organizational structure and make adjustments where necessary. All work performed under the

	<p>Essential Hospitals Institute is now unified under David Engler, senior vice president for leadership and innovation. As the membership continues to grow, it faces a broader variety of issues, including those on Capitol Hill. As a result, the association will add another lobbyist, to make a total of four on staff.</p> <ul style="list-style-type: none"> • The organization conducted a compensation study of all staff that generally found lagging net compensation and strong benefits. Needed salary adjustments were made. • America's Essential Hospitals recently held a joint meeting with the National Foundation to End Senior Hunger (NFESH). NFESH is a nonprofit organization that advocates on behalf of food insecure older people and would like to partner with the health care industry. The meeting, which showcased three member hospitals, promoted a preliminary exchange of ideas. It is clear there is strong interest in this issue among our members, though the association would like to broaden the scope from seniors to all ages. The organization is exploring whether there is an opportunity moving forward for a systematic activity among our hospitals. • In March, the Partnership for Medicaid published a report that proposed federally mandated uniformity for Medicaid metrics across Medicaid state agencies nationwide. The results would provide a uniform picture of Medicaid performance across programs and states and could prove valuable to the policy world. As a co-chair of the Partnership for Medicaid, America's Essential Hospitals will continue to follow and work with this information. This report was released to Capitol Hill in briefings March 14 and garnered a fair amount of attention. • Essential hospitals language has been infiltrating conversations in the health care and political arenas, including a White House-organized call March 20 with various hospitals and Vice President Biden. • The association has continued to forge connections on Capitol Hill, with particular attention to new committee assignments, including recently appointed Senate Finance Committee Chair Ron Wyden (D-OR). • The association has advocated that measures of outcomes, such as readmissions, should be adjusted for social determinants. The government does not currently allow this sort of adjustment. However, over the past six months, the National Quality Forum (NQF) has assembled a panel/taskforce (including several essential hospitals) to review this stance and the group has decided to support adjusting for sociodemographic factors. The panel is currently drafting a report for public discourse and America's Essential Hospitals is urging members to vocally support the proposal. The deadline for comments is April 16 and the association will distribute a draft statement to members on April 10. Various parties are likely to oppose the report, making it important to engage in this discussion. The basis of opposition is that there is potential to mask disparities and allow the hospital industry to undermine value-based purchasing. The NQF board will review this report, as well as public reaction, to determine its policy going forward.
Review and Approve Institute Board Nominations (Traylor)	<ul style="list-style-type: none"> • Under a 2013 bylaws revision, the association board of directors now appoints the Essential Hospitals Institute board of directors (this was previously done by a full membership vote). The Institute nominating committee made the following recommendations: <ul style="list-style-type: none"> ○ Proposed officers: Anna Roth, RN, MS, MPH, chair-elect/secretary; Leon Haley, MD, MHSA, treasurer

	<ul style="list-style-type: none"> ○ Proposed new directors: Delvecchio Finley, MPP; Erica Murray, MPA ○ Proposed re-elected directors: Susan Moffatt-Bruce, MD, PhD; Christine Neuhoff, JD <p><i>Traylor requested a motion to approve the Institute Board Nominations. There was a motion, a second, and unanimous approval of the Institute board candidates.</i></p>
Nominating Committee Report (Walker)	<ul style="list-style-type: none"> ● The association nominating committee met Feb. 3 to consider candidates for the 2014-2015 board of directors. Elections will be open for two weeks in April and the new board composition will be effective July 1. <ul style="list-style-type: none"> ○ Proposed officers: Reginald Coopwood, MD, treasurer; David Lopez, secretary; Johnese Spisso, MPA, RN, chair-elect. ○ Proposed new directors: John Haupert; Donna Sollenberger, MA; Roxane Townsend, MD ○ Proposed re-elected directors: Michael Belzer, MD; Timothy Goldfarb; George Hernandez Jr., JD; Sheldon Retchin, MD, MS, MSP ● There are currently two vacant director positions with unexpired terms created by the resignations of Arthur Gianelli and Alan Aviles. Wright Lassiter III and Ramanathan Raju, MD, MBA, were proposed to fill these vacant director positions. Both will serve effective immediately and be eligible for election to full terms in 2015. <p><i>Traylor requested a motion to approve the election of Wright Lassiter and Ram Raju to fill the director positions currently vacant and with unexpired terms. There was a motion, a second, and unanimous approval of the candidates.</i></p>
Membership Committee Report (Lopez and Staff)	<ul style="list-style-type: none"> ● America's Essential Hospitals is currently undergoing a dues restructuring process pending approval by the board in June 2014. This restructure serves to improve equity and growth for the organization's membership. ● The current dues structure charges a flat rate of \$57,900 for all systems, regardless of size or scope. The new dues structure will offer a rational pricing structure based on hospital expenses to incorporate variances among institutions and promote inclusion of smaller health systems. The organization and external consultants have constructed a plan that will minimize change for most members and will be competitive with other associations. ● The board reviewed accompanying material that illustrates nine tiers of dues, ranging from \$25,000 to \$500,000. Most members will pay \$65,000 or less and see a very small increase or decrease. No current members will reach \$500,000 in dues. It was noted that systems in the highest dues tiers are currently paying for multiple memberships and are not increasing from \$57,900, but rather, for example, from \$235,000. For those in tiers \$85,000 or higher, there will be a two-year phase in to alleviate budget constraints. ● The group discussed the consequences of potentially losing members, and staff noted that the members of concern will be large systems that are rarely engaged. For any systems seeing a significant increase, Siegel will be sure to have comprehensive individual conversations to discuss the potential changes. The organization is budgeting conservatively for the loss of four members. The group discussed the length of phase-in for systems with large increases and whether more time is needed. Staff responded that two years is the current timeframe, but that there is a cushion to approach this on a case-by-case basis for members that will need more time.

	<ul style="list-style-type: none"> The next steps will be to conduct a small market test and bring a final dues recommendation to the board at the June meeting for a formal vote.
Education Committee Report (Belzer)	<ul style="list-style-type: none"> Section 1115 Delivery System Reform Incentive Payment (DSRIP) waivers are now a part of the organization's educational programming through various mediums, including webinars, publications, and in-person meetings. VITAL2014 will again feature a "track" structure to include Executive Leadership, Clinical Leadership, Finance, and Patient Safety and Quality. Registration for the conference is ahead of schedule, with 60 registrants toward a goal of 300. For the first time, VITAL2014 will offer post-conference workshops. Marketing is making a concerted effort to advertise these events before attendees make travel arrangements. America's Essential Hospitals will conduct 50 webinars this year and follow a schedule that can accommodate late-breaking topics. Plans for 2015 distance learning programming will begin this summer and incorporate findings from a forthcoming member survey. At the committee's request, America's Essential Hospitals staff performed an analysis of webinar participation. Preliminary analytics indicate that participation increases with size among small and medium health systems, but declines with larger institutions. Future analyses will include webinar participation mapped to the four pillars of the association's strategic plan. Over the past year, the education committee has discussed ways to increase its members' participation at VITAL2014. They will now be integrated into the program as panel leaders, speaker introducers, and first-time attendee ambassadors.
Policy Advisory Committee Report (Walker)	<ul style="list-style-type: none"> The committee was very busy in 2013 developing criteria to define for federal designation hospitals committed to caring for the vulnerable. In 2013, the committee focused on the criteria and definition for a possible federal designation for hospitals committed to caring for the vulnerable. This spring, the committee will focus on assessing current and future forms of alternative Medicaid payments and state waivers. The committee will evaluate various methodologies and develop principles to which alternative Medicaid payment methods should adhere. The committee will present these principles to the board for review and approval at the June meeting.
Policy/Advocacy Update (Feldpush)	<ul style="list-style-type: none"> In December 2013, Congress voted to eliminate Medicaid disproportionate share hospital (DSH) payment cuts in fiscal year (FY) 2014 and delay FY 2015 cuts until FY 2016. This was a significant victory for essential hospitals and was spearheaded by advocacy and policy staff at America's Essential Hospitals. This legislation was part of a joint budget agreement act. An additional focus for DSH policy work has been related to legislation that would repeal Medicare's sustainable growth rate (SGR). The Senate Finance Committee passed legislation in December 2013 to repeal and replace the SGR. That bill also required the Health and Human Services (HHS) secretary to annually report on future needs for DSH. The reports would include information on uncompensated care and uninsurance by state, as well as Medicaid losses by hospital. Information from these reports will underscore the case for mitigating DSH cuts starting in FY 2016. In February, House and Senate lawmakers introduced a consensus bill to repeal the SGR that incorporated bills passed in the Senate Finance, House Ways

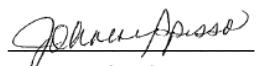
	<p>and Means, and House Energy and Commerce committees. This bill included important changes to Medicare physician payment, but did not include solutions for how to pay for the legislation (an estimated \$138 billion).</p> <ul style="list-style-type: none"> • As of March 31, because work had stalled on passing a permanent repeal of the SGR, a new, temporary patch was passed in the House by voice vote and was pending a vote in the Senate. (<i>This later passed in the Senate</i>). This legislation contained an additional one-year delay of the Medicaid DSH cuts, pushing them back to FY 2017. . This legislation also included our language for a report on DSH and required the Medicaid and CHIP Payment and Access Commission (MACPAC) to report annually on the state of Medicaid DSH, which likely will underscore the need for DSH in essential hospitals. America's Essential Hospitals has worked closely with Sens. Bill Nelson (D-FL) and Harry Reid (D-NV) on the report language. . • The board was briefed on projections for the upcoming November 2014 elections and changes in committee leadership. America's Essential Hospitals will continue to monitor all activities and correspond with appropriate individuals. • The organization recently partnered with the White House communications office to share stories from member hospitals about successfully enrolling patients in Affordable Care Act coverage and connecting the newly insured to services. As of late March, 6 million people were enrolled through the federal health insurance exchanges. • The board discussed the president's 2015 budget request and its impact on essential hospitals. Most notably, the request includes \$14.6 billion in cuts to Medicare indirect medical education (IME) over the next 10 years. It was noted that Congress is unlikely to adopt this budget, but that attention should be paid nonetheless to the stances within the proposal. • Other than continued work on the SGR, the remainder of the year—an election year—should be quiet with respect to legislative and policymaking activities. One of the association's main objectives will be making the case for federal designation of hospitals that demonstrate a commitment to serving all patients, particularly the most vulnerable, and that also <ul style="list-style-type: none"> ○ train the next generation of clinicians and allied health professionals; ○ provide comprehensive coordinated care; ○ provide specialized services, such as trauma, burn, and psychiatric care; and ○ improve public and population health in their communities. • This language and definition are seeing more use and exposure as policy efforts continue. The board discussed concern of others using the language and redefining it to meet their needs. Staff noted that while that is always possible, the association would promote on Capitol Hill its exclusive use for the designation concept. Across the organization, staff members are paying close attention to Section 1115 DSRIP waivers. The advocacy/policy department held a very successful webinar in late December 2013 and will publish an update to an advocacy research paper showcasing the value/experience of waivers across the country. • The group discussed networks of qualified health plans (QHPs) and the organization's efforts to attenuate their exclusion of essential hospitals. The federal Center for Consumer Information and Insurance Oversight recently produced a letter to issuers that plan to offer insurance products on the federal exchange in 2015 providing guidance to them on the number and type of essential community providers they must include in their networks. .
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	<ul style="list-style-type: none"> The Health Resources and Services Administration is expected to issue 340B Drug Pricing Program regulations in early June (referred to as the “mega-reg”). This will formalize the regulation of all program guidance for 340B administration. The group discussed the relationship of the program with health systems and pharmaceutical entities and what the regulations might entail. Once the rule is issued, there will be a comment period and the association will engage in the conversation. The association supports a delay of Medicare’s “two-midnight policy.” The enforcement of the new policy will likely be pushed back until at least March 2015, and the association will take more action as necessary. The Essential Hospitals Institute has been conducting research and analysis on readmissions penalties. This information may be used in legislative work going forward as the association seeks adjustments for social determinants. The board and staff discussed premium assistance. As the exchanges continue to take shape, the organization will try to better determine the extent to which the newly insured are able to pay their premiums and cost-sharing responsibilities, and what actions hospitals and their charitable foundations may take to assist patients with cost-sharing.
Impact Studies: Value-Based Purchasing and Readmissions (Engler)	<ul style="list-style-type: none"> Analytical work has been expanded and includes the completion of two impact studies, one on value-based purchasing (VBP) and one on readmissions. New software and continuous staff training have allowed the organization to do innovative research analysis, while improving data security. America’s Essential Hospitals may seek partnerships with external organizations, such as the American Hospital Association, to increase efficacy and avoid duplication. The new analytics team serves to streamline productivity and unity by bridging a gap between the Institute and association. The two impact studies feature infographics and analysis that will support quality improvement and advocacy/policy work. The analytics department has also conducted a hospital characteristics survey and report, to be published this spring. VBP determines a pool of incentive payments to hospitals that meet or exceed performance standards for select measures. The goal of this study was to examine the total financial impact of VBP on essential hospitals over the first two years of the program. The financial hit proved modest (roughly \$3 million), and hospitals that did well in 2013 are improving in 2014. This indicates that hospitals will do better over time with new domains and perform well on efficiency measures. The board asked about how the association can help outliers that are not performing as well, and staff offered examples of the Hospital Consumer Assessment of Healthcare Providers and Systems learning network, interest groups, and discussions via the website. The group also discussed the challenge essential hospitals face due to social determinants in their communities, though the study shows relatively strong quality metrics compared with the health care world at large. The Centers for Medicare & Medicaid Services (CMS) Hospital Readmissions Reduction Programs (HRRP) penalizes hospitals for readmissions occurring within 30 days of an index admission that exceed expected levels. These penalties are a percentage of payments and increase over time as more entities are included. The goal of this impact study was to examine the magnitude of the penalties on essential hospitals and compare the distribution of penalties among member and non-member hospitals.

	<ul style="list-style-type: none"> In both 2013 and 2014, members of America's Essential Hospitals had higher median penalties than non-members, although median penalties declined nationally and within the membership between 2013 and 2014. The board discussed these findings and whether there is a need to identify resources and that can alter the payment penalty formula. Staff is determining whether this should be a priority for the organization and discussed the likelihood that these penalties will become more common now that there is precedent.
Finance Report (Lopez)	<ul style="list-style-type: none"> An audit was recently completed and the financial statements will be distributed following the investment, audit and compliance committee's review. 2013 ended with an income of \$8.07 million and expenses of \$6.78 million, leaving a surplus of \$1.29 million before rebranding costs funded from reserves (\$166,000) and investment gains (\$395,000). This surplus is \$428,000 better than the last projection, primarily due to savings in project development costs, salaries and fringe, advertising campaigns, office expenses, and travel/professional development. Total net assets are almost \$6.8 million, representing one year of operating expenses in reserve. The board was asked to approve the revised 2014 budget, which reflects the elimination of \$485,000 in support of the Institute and a reallocation of those funds to salaries, fringe, and office relocation. CMS reclassified 2012 and 2013 savings from liability to earned revenue. This reclassification made \$485,000 of association support for Institute labor/programmatic costs unnecessary, and marks the first time the Institute is self-supporting. Other adjustments to the revised budget included salary market adjustments as recommended by external consultants and the addition of a staff lobbyist to strengthen political relationships. The salary adjustments were based on an extensive compensation study that reviewed the salaries of all staff in the context of the market. The financial impact of these two changes total \$237,000. <p><i>Lopez requested a motion to approve the 2014 revised budget. There was a motion, a second, and unanimous approval of the 2014 revised budget.</i></p> <ul style="list-style-type: none"> Gold reviewed long term projections, including the upcoming office move. This move is unavoidable, as the current building will be torn down at the end of 2015. Leadership is currently meeting with commercial brokers and architects to plan the relocation. The organization currently pays \$42.50 per square foot of office space, far below the current market of roughly \$70 per square foot. The board reviewed graphics indicating projections for 2014 (4.2 percent profit margin) which later dips in 2015-2017. To achieve a 5 percent profit margin, expenses will be need to be reduced by 9 to 10 percent. The finance committee has not formerly discussed this, but will review the numbers going forward. It was noted that the projections are generally conservative and will likely be surpassed. The organization has implemented various measures to heighten fraud prevention, including distribution of duties, electronic/direct deposit transactions, automatic payments, and electronic timesheets. The association continually passes payment card industry data security standard tests, as well as Federal Information Security Management Act compliance (requirements for government contractors). The board discussed the possibility of an external internal auditor.
Rollout of New	<ul style="list-style-type: none"> The association launched a new website in early February 2014 after more than a

Association Website (Graziano)	<p>year of research and development. Much of the work occurred concurrently with the association's rebranding process.</p> <ul style="list-style-type: none"> • The new website features vast improvements in navigation and design, and promotes and showcases the organization's work. • The homepage portraits and other site elements reflect the strongly human-centric approach to the site, as embodied in the "essential people, essential communities, essential hospitals" tagline. • The site also incorporates a new "Essential Insights" blog that focuses on the work members do in their communities. • The website is organized by four main topic areas: advocacy and policy, quality, education, and research. • There is a social media aspect to the new site, including the ability for members to create profiles and connect with others through the site's Member Network. This will encourage members to engage with one another and the organization.
Executive Session	The board went into executive session and the meeting was adjourned at 4:49 pm.

Submitted by:


5/8/14

Johnese M. Spisso, RN, MPA
Secretary



BOARD OF DIRECTORS AND SENIOR EXECUTIVE CONFLICT OF INTEREST POLICY

Article I

PURPOSE

The purpose of this conflict of interest policy is to protect America's Essential Hospitals' and Essential Hospitals Institute's (collectively referred to as America's Essential Hospitals) interest when its Board considers a transaction or arrangement that might benefit the private interest of a member of the board or a senior executive of America's Essential Hospitals. The policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest applicable to non-profit and tax-exempt organizations. It applies to matters brought for approval by the Board or any of their committees, regarding which a board member or a senior executive of America's Essential Hospitals has a financial interest (see definitions in Article II).

Article II

DEFINITIONS

1. Senior Executive

Senior executives include America's Essential Hospitals' president and CEO, chief financial officer and vice presidents.

2. Interested Person

An interested person includes any member of the board or any senior executive who has a direct or indirect financial interest in a transaction or arrangement as defined below.

3. Financial Interest

A person has a financial interest in a transaction coming before the board or other committee if the person has directly, or indirectly through business, investment or family (including immediate family and any domestic partner who resides in the person's household):

- a. An ownership or investment interest in the other party to the proposed transaction or arrangement, or
- b. A compensation arrangement with the other party to the proposed transaction or arrangement, or

- c. A potential ownership or investment interest in, or compensation arrangement with, the other party to the proposed transaction or arrangement.

Compensation includes direct and indirect remuneration as well as gifts or favors that are substantial in nature.

A financial interest is not necessarily a conflict of interest. Under Article III, Section 2, a person with a financial interest has a conflict of interest only if it is determined that a conflict of interest exists.

4. Conflict of Interest

A financial interest results in a conflict of interest if:

- a. the proposed transaction creates an opportunity for private benefit;
- b. the opportunity would directly or indirectly redound to the benefit of the interested person; and
- c. the Board or other committee considering the transaction deems the opportunity for benefit to be material under the circumstances.

5. Board

In most cases, the body considering a proposed transaction pursuant to this policy will be the board. Where instead another committee is considering the transaction in question, then references to the board shall be deemed to refer the body that is actually considering the transaction.

Article III

PROCEDURES

1. Duty to Disclose

- a. At the time an actual or possible conflict of interest arises or the interested person becomes aware of it, he or she must disclose the existence of his or her financial interest to America's Essential Hospitals' board chair, CFO, or to the executive committee. At such time as a senior executive independently becomes aware of any such financial interest, he or she shall report it to the board chair and to the interested person. Annually, the CEO shall provide the board with a summary report of all financial interests that became known to him or her during the prior year.
- b. The interested person shall disclose such material facts as requested, and shall be given the opportunity to disclose any additional material facts, to the board. In no event shall the interested person participate in formal discussion or action on the proposed transaction without properly disclosing his or her financial interest.

2. Determining Whether a Conflict of Interest Exists

After the interested person has disclosed material facts to the board, he or she shall leave the meeting during the deliberation on the existence of a conflict of interest. The board shall determine whether the opportunity for benefit is material under the circumstances, and thus whether a conflict of interest exists with respect to the transaction in question.

3. Procedures for Addressing a Conflict of Interest

If a conflict of interest is found, the following procedures shall apply to consideration of the transaction:

- c. The board shall consider whether America's Essential Hospitals, exerting reasonable efforts, can obtain a more advantageous transaction or arrangement that would not give rise to a conflict of interest.
- d. If appropriate, the board chair shall appoint a disinterested person or subcommittee (investigator) to investigate alternatives to the proposed transaction and report findings back to the board.
- e. Any such investigator shall exercise due diligence and assess the reasonable availability of a more advantageous transaction that would not give rise to a conflict of interest. If the investigator concludes that a preferable alternative is not reasonably available, then it shall consider whether the proposed transaction is fair and reasonable to America's Essential Hospitals' best interest. The investigator shall report its conclusion on each matter to the board.
- f. The interested person may make a presentation to the board, but after such presentation, he or she shall leave the meeting during the discussion of and vote on the transaction giving rise to the conflict of interest.
- g. If after consideration of any reports and after due deliberation, the board concludes that a more advantageous transaction is not reasonably attainable without conflict of interest, it shall determine by majority vote of disinterested members whether the proposed transaction is fair and reasonable to America's Essential Hospitals and in America's Essential Hospitals best interest. It shall approve or disapprove the transaction or arrangement in conformity with such determination.
- h. With respect to potential conflicts arising between meetings of the board, the CEO shall determine whether it is in America's Essential Hospitals' best interest to enter into such transaction, subject to the review and approval of the board at its next meeting. The board may void any such contract or transaction that it determines is a conflict of interest.

4. Violations of the Conflicts of Interest Policy

- a. If the board has reasonable cause to believe that an interested person has failed to disclose actual or possible conflicts of interest, it shall inform such person of the

basis for its belief and afford him or her an opportunity to explain the alleged failure to disclose.

- b. If, after hearing the explanation and making such further investigation as may be warranted in the circumstances, the board determines that the member has in fact failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

5. Confidentiality.

All such proceedings and deliberations of the board shall be held in executive session.

Article IV

RECORDS OF PROCEEDINGS

The minutes of the board shall contain:

1. The name of any person found to have a financial interest in connection with an actual or possible conflict of interest; the nature of the financial interest; any action taken to determine whether a conflict of interest was present; and the determination as to whether a conflict of interest in fact existed.
2. The names of the persons present and their votes relating to the determination of conflict, and those relating to approval or disapproval of the transaction; and the content of the discussion, including any alternatives to the proposed transaction.

Article V

RECUSAL

1. Compensation

A voting member of the board who receives compensation, directly or indirectly, from America's Essential Hospitals for services is precluded from voting on matters pertaining to that member's compensation.

2. Consideration of Conflict

An interested person shall recuse himself or herself from any deliberations or vote of the board with respect to the existence of a conflict or of a violation of this conflicts policy; or, if a conflict is determined to exist, with respect to the underlying transaction or other disposition of the conflict. Only the disinterested members of the board shall participate in such deliberations or vote.

Article VI

ANNUAL STATEMENTS

Each member of the board and America's Essential Hospitals senior executives shall annually sign a statement which affirms that he or she –

1. Has received a copy of the conflicts of interest policy,
2. Has read and understands the policy, and
3. Agrees to comply with the policy.

Article VII

PERIODIC REVIEWS

To ensure that America's Essential Hospitals operates in a manner consistent with its exempt purposes and that it does not engage in activities that could jeopardize its status as an organization exempt from federal income tax, periodic reviews shall be conducted, and the CEO or CFO shall certify America's Essential Hospitals' compliance. The periodic reviews shall, at a minimum, include the following subjects:

1. Whether compensation arrangements and benefits are reasonable, are based on comparable information and are at arm's-length.
2. Whether acquisitions of services result in impermissible private benefit.
3. Whether partnership and joint venture arrangements and arrangements with other organizations conform to written policies, are properly recorded, reflect reasonable payments for goods and services, further America's Essential Hospitals purposes and do not result in impermissible private benefit.

Article VIII

USE OF OUTSIDE ADVISORS

America's Essential Hospitals may, in its discretion, use outside advisors (e.g., its auditors) in conducting the periodic reviews pursuant to Article VII. The use of outside advisors will not relieve the board of responsibility to ensure that periodic reviews are conducted; nor the CEO or CFO of responsibility to certify compliance, based on the advisors' review.



BOARD OF DIRECTORS & SENIOR EXECUTIVE CONFLICT POLICY ACKNOWLEDGEMENT

As a board member of America's Essential Hospitals and/or the Essential Hospitals Institute, I have received a copy of the organization's conflict of interest policy. All of my questions concerning the policy and its procedures have been answered to my satisfaction. I understand that I am responsible for following this policy and that failure to do so may result in discipline, up to and including my removal from office or from the organizations' board. In the event that I need further clarification of the policy or its procedures, I understand that I should contact the board chair or the president and CEO.

Disclosure of Actual or Potential Conflicts of Interest (indicate "none" if applicable or include a separate sheet of paper, if necessary):

SIGNATURE AND CERTIFICATIONS

I hereby certify that I have read and understood this **conflict** of interest policy, agree to comply with this policy, and understand that because America's Essential Hospitals is a 501(c) (6) organization and Essential Hospitals Institute is a 501(c) (3), in order to maintain their federal tax exemption they must engage primarily in activities which accomplish one or more of their tax-exempt purposes. If at any time following the submission of this acknowledgement I become aware of any actual or potential conflicts of interest, or if the information provided below becomes inaccurate or incomplete, I will promptly notify America's Essential Hospitals' president and CEO in writing.

Further, I hereby certify that, to the best of my knowledge and belief, the information I have provided in this questionnaire is correct and complete and is not misleading. Based on my knowledge, this questionnaire does not contain any untrue statement of material fact, or fail to state a material fact necessary, in light of the circumstances, to prevent my answers from being misleading.

(Print or Type Name)

(Position and Organization Name)

(Signature)

(Date)

Check the capacity you are serving as:

- America's Essential Hospitals Board of Directors or
- Essential Hospitals Institute Board of Directors

PLEASE EXECUTE, SCAN and EMAIL THIS ACKNOWLEDGEMENT
TO THE ATTENTION OF RHONDA GOLD at rgold@essentialhospitals.org



America's Essential Hospitals | *Board Member Expectations*

MINIMUM EXPECTATIONS FOR ALL BOARD MEMBERS

Provide organizational, strategic, and financial stewardship of the association

Read and understand the organization's bylaws, strategic plan, and financial statements

Consider issues brought before the board in the context of broader membership needs (not individual member needs)

Support the majority decision of the board

Attend two out of three in-person board meetings annually

Prepare for meetings

Actively participate during meetings

Serve on one to two additional committees

Attend conference calls and committee meetings

Serve as a liaison between the committee(s) and the board

Make all reasonable efforts to attend at least one education or other in-person association meeting annually

Spring Policy Assembly (usually in March)

VITAL, the association's annual conference (usually in June)

Fall Policy Assembly (in October, or in December during election years)

Encourage hospital staff to participate in association activities

Distance learning programs

Interest group sessions

In-person meetings

Fellows Program

Data collection efforts, (including the Annual Hospital Characteristics Survey)

Support the association's corporate relations activities

Participate on at least one business advisory council call per year. These biannual calls bring together premier corporate affiliate members and leaders within the membership to discuss insights on industry trends. Attend the business advisory council networking event during VITAL. Visit with and thank sponsors at association events

Assist with membership recruitment and retention activities, as requested

Advocate in Washington, DC, on issues important to our community of members, as requested

To Congress, the administration, federal agencies, other

Support association media work on behalf of essential hospitals as requested, including being available for media interviews

LEGAL DUTIES FOR ALL BOARD MEMBERS¹

Duty of Care

This duty is very broad, requiring officers and directors to exercise ordinary and reasonable care in the performance of their duties, exhibiting honesty and good faith. Officers and directors must act in a manner which they believe to be in the best interests of the association, and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under similar circumstances.

Duty of Loyalty

This is a duty of faithfulness to the association. This means that officers and directors must give undivided allegiance to the association when making decisions affecting the association. In other words, officers and directors cannot put personal interests above the interests of the association.

Duty of Obedience

This duty requires officers and directors to act in accordance with the organization's articles of incorporation, bylaws, and other governing documents, as well as all applicable laws and regulations.

¹ Tennenbaum S. Legal Duties of Association Board Members. American Society of Association Executives Center Collection.

<http://www.asaecenter.org/Resources/whitepaperdetail.cfm?ItemNumber=12217>. Accessed February 2015.



America's Essential Hospitals | *Board Member Expectations (continued)*

EXPECTATIONS FOR OFFICERS

ALL OFFICERS

Serve on executive committee
Serve on compensation committee

CHAIR

Chair the board and executive committee
Serve on nominating committee
Deliver chair's address at major association conferences (VITAL and Policy Assembly, for example)
Pass chair's gavel to incoming chair during VITAL
Participate in town hall meeting during VITAL
Approve committee appointments

PAST CHAIR

Serve on nominating committee
Participate in town hall meeting during VITAL

CHAIR-ELECT

Chair the nominating committee
Chair the compensation committee
Receive chair's gavel at VITAL and give short address
Participate in town hall meeting during VITAL

SECRETARY

Serve on finance committee
Serve on investment, audit, and compliance committee
Review and sign minutes of each board meeting

TREASURER

Chair finance committee
Serve on investment, audit, and compliance committee
Support preparation of the annual financial report
Support preparation of the annual audit

UPCOMING BOARD MEETINGS

Tuesday, June 23, 2015
11 am-5 pm

Monday, October 26, 2015
11 am-5 pm

Monday, March 7, 2016
11 am-5 pm

Tuesday, June 14, 2016
11 am-5 pm

UPCOMING IN-PERSON MEETINGS

VITAL2015
June 24-26, 2015
San Diego
vital.essentialhospitals.org

Policy Assembly
October 27-28, 2015
Washington, DC
policyassembly.essentialhospitals.org

Policy Assembly
March 8-9, 2016
Washington, DC
policyassembly.essentialhospitals.org

VITAL2016
June 15-17, 2016
Boston
vital.essentialhospitals.org

Questions? Contact Kristine Metter, vice president for member services at 202-585-0573 or kmetter@essentialhospitals.org.

Articles

November 1, 1999

AUTHORS

Jeffrey S. Tenenbaum

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Association officers, directors, committee members, and others involved in the association's governance structure are often unclear as to their roles and responsibilities. And for good reason - some rights and obligations are determined by law, others by the association's articles of incorporation and bylaws, and still others by written policies and procedures or more informal arrangements. The following article is designed to clarify the delegation of duties, explain the fiduciary duties imposed by law on association officers and directors, and suggest ways to protect volunteer leaders from personal liability.

Roles and Responsibilities.

The *board of directors* is the governing body of the association, responsible for the ultimate direction of the management of the affairs of the organization. The board is responsible for *policymaking*, while employees (and to a certain extent, officers) are responsible for executing *day-to-day management* to implement board-made policy. However, the ultimate legal responsibility for the actions (and inactions) of the association rests with the board.

The board can act legally only by consensus (majority vote of a quorum in most cases) and only at a *duly constituted and conducted meeting*, or by *unanimous written consent* (in most states, boards cannot act by mail, fax or electronic ballot). The board may delegate authority to act on its behalf to others such as committees, but, in such cases, the board is still legally responsible for any actions taken by the committees or persons to whom it delegates authority. An *individual* board member has no individual management authority simply by virtue of being a member of the board. However, the board may delegate additional authority to a board member such as when it appoints board members to committees. In a similar fashion, an *officer* has only the management authority specifically delegated in the bylaws or by the board (although the delegated authority can be general and broad).

Committees have no management authority except for that delegated to them by the bylaws or by the board. Furthermore, under most state nonprofit corporation laws, certain functions may not be delegated by the board to committees. For example, in many states, the board may not delegate to committees the power to elect officers, fill vacancies on the board or any of its committees, amend the bylaws, or approve a plan of merger or dissolution.

Employees have no management authority except that specifically delegated to them in the bylaws or by the board. For example, most associations' bylaws delegate to the chief staff executive the responsibility for the day-to-day operations of the association's office(s), including the responsibility to hire, train, supervise, coordinate, and terminate the professional staff of the association, as well as the responsibility for all staffing and salary administration within guidelines established by the board.

Members have no management authority, as such authority is held by the board of directors. However, state nonprofit corporation laws generally reserve to members the right to remove officers and directors and to amend the association's articles of incorporation, among other rights. Under some associations' bylaws, certain matters, such as the amendment of the bylaws or the election of officers and directors, must be submitted to the membership for a vote. However, most other matters generally are not submitted to the full membership, but rather are handled by the board, one or more of its committees, or the officers or employees of the association.

Fiduciary Duty.

Those in positions of responsibility and authority in the governance structure of an association - both volunteers who serve without compensation and employed staff - have a fiduciary duty to the organization, including duties of care, loyalty and obedience. In short, this means they are required to act *reasonably, prudently and in the best interests of the organization*, to avoid *negligence and fraud*, and to avoid *conflicts of interest*. In the event that the fiduciary duties of care, loyalty or obedience are breached, the individual breaching the duty is potentially liable to the association for any damages

caused to the association as a result of the breach. This fiduciary duty is a duty to the association as a whole; even those who only serve on a particular committee or task force owe the fiduciary obligation to the entire association.

1. Duty of Care. This duty is very broad, requiring officers and directors to exercise *ordinary and reasonable* care in the performance of their duties, exhibiting honesty and good faith. Officers and directors must act in a manner which they believe to be *in the best interests of the association*, and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under similar circumstances. The "business judgement rule" protects officers and directors from personal liability for actions made in poor judgment as long as there is a reasonable basis to indicate that the action was undertaken with due care and in good faith. The duty of care also imposes an obligation to protect any confidential information obtained while serving the association.

2. Duty of Loyalty. This is a duty of faithfulness to the association. This means that officers and directors must give undivided allegiance to the association when making decisions affecting the association. In other words, officers and directors cannot put personal interests above the interests of the association. Personal interests may include outside business, professional or financial interests, interests arising from involvement in other organizations, and the interests of family members, among others. Officers and directors should be careful to disclose even *potential* conflicts of interest to the board of directors, and should recuse themselves from deliberation and voting on matters in which they have personal interests. For pervasive and continuing conflicts - such as a director of the association concurrently serving on the board of a competing association - resignation from the individual's association leadership post or from the outside conflicting responsibility may be required. Officers and directors can have business dealings with the association, but such transactions must be subject to considerable scrutiny. In such event, officers and directors must fully disclose any personal interests to the board of directors, and the terms of any transaction must be fair to the association. In addition, state nonprofit corporation statutes frequently provide specific procedures for dealing with transactions in which officers or directors have conflicts of interest.

Corporate Opportunities Doctrine. The duty of loyalty specifically prohibits competition by an association officer or director with the association itself. While officers and directors generally may engage in the same "line of business" or areas of endeavor as the association, it must be done in good faith and without injury to the association. One form of competition that is not permitted, however, is appropriating "corporate opportunities." A corporate opportunity is a prospect, idea or investment that is related to the activities or programs of the association and that the individual knows, or should know, may be in the best interests of the association to accept or pursue. An association officer or director may take advantage of a corporate opportunity independently of the association *only* after it has been offered to, and rejected by, the association.

3. Duty of Obedience. This duty requires officers and directors to act in accordance with the organization's articles of incorporation, bylaws and other governing documents, as well as all applicable laws and regulations.

Reliance on experts. Unless an officer or director has knowledge that makes reliance unwarranted, an officer or director, in performing his or her duties to the organization, may rely on written or oral information, opinions, reports, or statements prepared or presented by: (i) officers or employees of the association whom the officer or director believes in good faith to be reliable and competent in the matters presented; (ii) legal counsel, public accountants, or other persons as to matters which the officer or director believes in good faith to be within the person's professional or expert competence; or (iii) in the case of reliance by directors, a committee of the board on which the director does not serve if the director believes in good faith that the committee merits confidence.

Willful ignorance and intentional wrongdoing. Directors cannot remain willfully ignorant of the affairs of the association. A director appointed as treasurer, for example, with limited knowledge of finance cannot simply rely on the representations and reports of staff or auditors that "all is well" with the association's finances. Moreover, officers and directors acting *outside of or abusing* their authority as officers and directors may be subject to personal liability arising from such actions. Furthermore, officers or directors who, in the course of the association's work, *intentionally* cause injury or damage to persons or property may be personally liable, even though the activity was carried out on behalf of the association.

Reducing Personal Liability Risk.

Association officers and directors can help minimize their risk of personal liability by doing the following:

- * Being thoroughly and completely prepared before making decisions.
- * Becoming actively involved in deliberations during board meetings, commenting as appropriate, and making inquiries and asking questions where prudent and when such a need is indicated by the circumstances.
- * Making decisions deliberately and without undue haste or pressure.
- * Insisting that meeting minutes accurately reflect the vote counts (including dissenting votes and abstentions) on actions taken at meetings.
- * Requesting that legal consultation be sought on any matter that has unclear legal ramifications.
- * Requesting that the association's accountants assess and evaluate any matter that has significant financial ramifications.
- * Obtaining and carefully reviewing both audited and unaudited periodic financial reports of the association.
- * Attending the association's meetings and reading the association's publications carefully to keep fully apprised of the organization's policies and activities.
- * Reviewing from time to time the association's articles of incorporation, bylaws and other governing documents.
- * Avoiding completely any conflicts of interest in dealing with the association and fully disclosing any potential conflicts.

Liability Protection.

If preventive risk management fails, the liability of association officers and directors can be limited through indemnification by the association, insurance purchased by the association, and state volunteer protection laws.

Apparent Authority.

In the landmark 1982 case, *American Society of Mechanical Engineers v. Hydrolevel*, the U.S. Supreme Court determined that an association can be held liable for the actions of its officers, directors and other volunteers (including actions which bind the association financially), even when the association does not know about, approve of, or benefit from those actions, as long as the volunteer reasonably appears to outsiders to be acting with the association's approval (i.e., with its "apparent authority"). The Supreme Court made clear that associations are to be held strictly liable for the activities of volunteers that have even the apparent authority of the association. Even if an association volunteer does not in fact have authority to act in a particular manner on behalf of the association, the law will nevertheless hold the association liable if third parties reasonably believe that the volunteer had such authority. The law thus requires an association to take reasonable steps to ensure that the scope of its agents' (e.g., officers, directors and committee members') authority is clear to third parties, and that agents are not able to hold themselves out to third parties as having authority beyond that which has been vested in them by the association - for example, by regulating access to association letterhead stationery.

Antitrust.

Associations are subject to strict scrutiny under both federal and state antitrust laws. The Sherman Act, the principal federal antitrust statute, prohibits "contracts, combinations, or conspiracies ... in restraint of trade." By their very nature, associations are a "combination" of competitors, so one element of a possible antitrust violation is always present, and only some action by the association that unreasonably restrains trade needs to occur for there to be an antitrust violation. Consequently, associations are common targets of antitrust plaintiffs and prosecutors.

The consequences for violating the antitrust laws can be severe. A conviction can carry stiff fines for the association and its offending leaders, jail sentences for individuals who participated in the violation, and a court order dissolving the association or seriously curtailing its activities. The antitrust laws can be enforced against associations, association members, and the association's employees by both government agencies and private parties (such as competitors and consumers) through treble (triple) damage actions. As the Sherman Act is a criminal conspiracy statute, an executive who attends a meeting at which competitors engage in illegal discussions may be held criminally responsible, even if he or she says nothing at the meeting. The executive's attendance at the meeting may be sufficient to imply acquiescence in the discussion, making him or her liable to as great a penalty as those who actively participated in the illegal agreement.

Common antitrust claims against associations include price-fixing (any explicit or implicit understanding affecting the price of a member's product or service is prohibited, even if the understanding would benefit consumers), group boycotts / concerted refusals to deal, customer allocation or territorial division, bid-rigging, and illegal tying arrangements. Antitrust-sensitive areas of association activity include

membership restrictions, standard setting, certification and self-regulation, statistical surveys, and information exchange programs, among others.

To avoid antitrust liability, associations should adopt a formal antitrust compliance program, and this policy should be distributed regularly to all association officers, directors, committee members, and employees. The policy should require, among other conditions, that all association meetings be regularly scheduled - with agendas prepared in advance and reviewed by legal counsel - and that members be prohibited from holding "rump" meetings. Above all else, members should be free to make business decisions based on the dictates of the market - not the dictates of the association. Any deviation from this general principle, such as adoption of a Code of Ethics that infringes on members' ability to make fully independent business decisions, should be approved by legal counsel.



America's Essential Hospitals

2013-2018 Strategic Plan

Strategic Planning Committee Members

Arthur A. Gianelli (*Chair*)

Chief Executive Officer/President
NuHealth/Nassau University Medical Center
East Meadow, NY
America's Essential Hospitals Executive Committee

Kirk A. Calhoun, MD

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University of Texas Health Science Center at Tyler
Tyler, TX
America's Essential Hospitals Executive Committee

Reginald W. Coopwood, MD

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Regional Medical Center at Memphis
Memphis, TN
America's Essential Hospitals Executive Committee and Essential Hospitals Institute Board

Don Goldmann, MD

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Essential Hospitals Institute Board

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America's Essential Hospitals Executive Committee

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Chief Executive Officer
Contra Costa Regional Medical Center and Health Centers
Martinez, CA
Essential Hospitals Institute Board

Bruce Schroffel

Chief Executive Officer
University of Colorado Health
Aurora, CO
America's Essential Hospitals Member

Thomas P. Traylor

Vice President, Federal, State and Local Programs
Boston Medical Center
Boston, MA
America's Essential Hospitals Executive Committee

Introduction

America's Essential Hospitals, formerly the National Association of Public Hospitals and Health Systems (NAPH), has a rich history and lengthy record of accomplishments on behalf of its members. Since its inception, America's Essential Hospitals has been well recognized for its expertise on issues affecting care for the country's most vulnerable patients. This deep knowledge revolves around not only the organization's strenuous advocacy efforts, but also its contributions toward research on safety net issues, improving quality of care, and furthering good governance among its members.

The association has undergone a series of organizational changes over the past two years, from the retirement of its founder and longtime executive director to the hiring of a new president and CEO. Several new staff also have joined the senior management team, which has worked to transition America's Essential Hospitals as it strives to reflect the rapidly changing health care landscape. During this transition, the 2010-2013 strategic plan served as an effective roadmap for members, the governance boards, and staff.

In 2012, America's Essential Hospitals embarked on a yearlong process to create a new strategic plan designed to reflect its members' evolving needs and to set the stage for the next five years of association programming and growth. The planning process was comprehensive, including interviews with members and staff, focus group research, an electronic member survey, and a daylong joint session of the America's Essential Hospitals executive committee and the board of the Essential Hospitals Institute (formerly the National Public Health and Hospital Institute). The process was led by the newly formed strategic planning committee, which includes representation from the America's Essential Hospitals executive committee, the Essential Hospitals Institute board, and the membership.

In light of the continued evolution of health care, the strategic planning committee also reviewed and assessed the current association vision and mission statements. The committee recommends revisions that will merge the vision and mission statements into a more concise and future-focused single mission statement.

During the daylong planning session, our leaders and partners recognized that America's Essential Hospitals also needs a consensus statement regarding the commitment to service prospective member organizations should embody when they seek to join. These discussions resulted in a new service commitment statement, which America's Essential Hospitals will introduce to its members.

Mission Statement

The America's Essential Hospitals mission and vision statements have provided a solid foundation for the association's work for many years. However, since the implementation of the previous strategic plan, the landscape for America's Essential Hospitals, internally and externally, has changed significantly:

- Significant legislative actions have been taken.
- Health care delivery has undergone dramatic changes.
- The association has seen leadership changes.
- Association membership has grown and diversified.
- The association's and institute's program portfolios have expanded, especially in research and quality improvement.

The committee wanted to ensure America's Essential Hospitals has a comprehensive statement that reflects these changes, captures its mission and that of its members, and builds on the transformational work of the previous strategic plan.

America's Essential Hospitals Mission Statement

America's Essential Hospitals champions excellence in health care for all, regardless of social or economic circumstance, and advances the work of hospitals and health systems committed to ensuring access to care and optimal health for America's most vulnerable people.

America's Essential Hospitals membership has grown and diversified, a trend expected to continue. The current membership now comprises a wide variety of hospitals and health systems, including public hospitals, voluntary nonprofits, and academic medical centers. Many have complex governance structures. During the planning process, it became clear that America's Essential Hospitals must publicly define, through a shared commitment to service, the values that bind its members together.

America's Essential Hospitals Members' Commitment to Service

America's Essential Hospitals members commit to providing access to high-quality health care to all, especially to vulnerable populations. We are innovative hospitals and health systems that constantly strive to deliver the most efficient and effective care for those in greatest need, improving patient outcomes and quality of life in the communities we serve.

Strategic Plan Overview

The strategic planning committee did not seek to dramatically alter the association's strategic direction. An understanding of the challenges and opportunities in the delivery of care to vulnerable populations, cultivated throughout the organization's history, remains core to America's Essential Hospitals' identity and the work it pursues. This remains even as it has undergone a major transition coinciding with its current plan: new leadership, stepped-up membership growth, and major new Essential Hospitals Institute grants and contracts designed to support members' health care delivery and finance transformation. The committee believes America's Essential Hospitals need not move in a fundamentally different direction over the next five years, especially as it progresses through the early stages of initiatives launched by its mostly new leadership team under the guidance of the 2010 strategic plan.

Common themes emerged from the interviews, focus groups, leadership meetings, and electronic member survey held over the course of 2012. The themes included broad areas of focus and a series of underlying competencies that will be critical to America's Essential Hospitals' ability to execute the strategic plan. Strategic planning committee members purposefully developed a high-level framework for the new plan with the understanding that the association will periodically review the plan over its five-year course. The America's Essential Hospitals executive committee will use the plan to evaluate the association's performance, and staff will use it to guide their annual work plans.

The strategic plan contains four broad strategic pillars, each supported by two priorities. Advocacy is intentionally listed first here, given the responses from members during the planning process. Members view the association's role as a champion of its members and their patients as a critical priority. These are the four pillars:

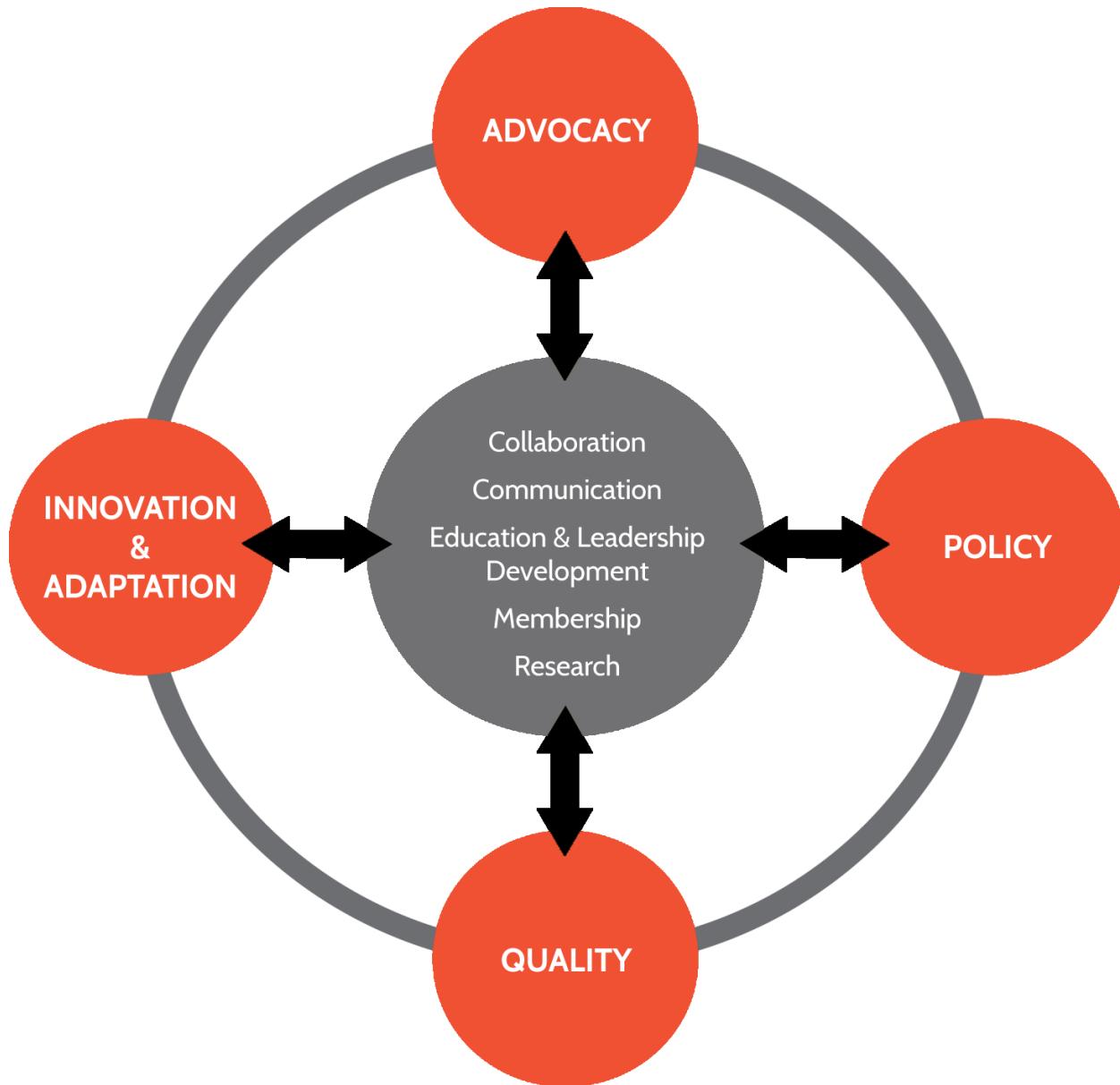
1. Advocacy
2. Policy
3. Quality
4. Innovation and Adaptation

The strategic planning committee also recognized that for America's Essential Hospitals to successfully execute a new strategic plan, it must continually engage in a series of underlying competencies that provide crucial support for the four pillars:

- Collaboration
- Communication
- Education and Leadership Development
- Membership
- Research

Subsequent pages outline the four pillars, supporting priorities, and relevant cross-cutting competencies in more detail. The following graphic (next page) provides a visual overview of the four pillars and their interconnected relationship with the competencies.

America's Essential Hospitals Strategic Model



Strategic Pillars

Advocacy Pillar

America's Essential Hospitals is a highly respected and credible national voice on issues that affect hospitals and health systems that provide care to vulnerable populations. Its members expect the association to ensure that opinion leaders and decision-makers understand the value of the services they provide and the costs they incur. America's Essential Hospitals has a longstanding focus on advocacy and an ongoing commitment to engage on those issues that directly impact members' ability to provide high-quality and innovative care to all, regardless of social and economic circumstance. These priorities support the advocacy pillar:

Priority: America's Essential Hospitals will advocate before Congress and the executive branch for the resources needed for hospitals and health systems to care for vulnerable populations – including the uninsured and underinsured – and provide essential community services, such as critical care, emergency preparedness, enabling services, public health services, and health care workforce training.

Priority: America's Essential Hospitals will support the continued development of innovative health care delivery and the provision of integrated, seamless, patient-centered care, particularly for vulnerable patient populations, such as the elderly; the poor; those with complex medical, behavioral, or long-term care needs; the newly eligible; and the remaining uninsured.

Policy Pillar

Inextricably linked and equally important to America's Essential Hospitals' advocacy work is the effort to impact federal policy in the legislative, administrative, and judicial branches of government. Members value this aspect of the association and are invested in America's Essential Hospitals broadening its work in the policy arena. Through further robust policy development activities, the association can bring to the table policy ideas that will secure the ability of essential hospitals – those with a safety net role – to care for their patients while improving the overall health care delivery system. America's Essential Hospitals is committed to fully engaging its members in the proactive development of policy based on sound evidence and consistent with members' service commitment. These priorities support the policy pillar:

Priority: America's Essential Hospitals will be viewed as a national thought leader with respect to policy development on issues concerning the delivery of care to vulnerable populations and the provision of essential community services.

Priority: America's Essential Hospitals will fully engage member hospitals and health systems in policy development work to generate strong positions and recommendations that represent the shared interests of the association's members.

Quality Pillar

America's Essential Hospitals occupies a unique position in the quality arena because of its members' dedication to and experience with care for vulnerable populations. America's Essential

Hospitals will continue to leverage this position and serve as a resource and champion for its members as they strive to provide high-quality, safe, and affordable care that eliminates health care disparities. Since carrying out its previous strategic plan, America's Essential Hospitals has significantly expanded the breadth of its quality portfolio. This work supports member quality efforts and informs the association's policy and advocacy efforts. America's Essential Hospitals is committed to a collaborative and strategic approach to quality, fully understanding that partnerships are critical to effectively and efficiently accomplishing this work. These priorities support the quality pillar:

Priority: America's Essential Hospitals will proactively identify and disseminate evidence-based best practices that will raise the quality of care for all – especially for vulnerable populations.

Priority: America's Essential Hospitals will work tirelessly to communicate its members' quality leadership to decision-makers and opinion leaders.

Innovation and Adaptation Pillar

America's Essential Hospitals members have pioneered many of the most innovative health care strategies and models over the past decade. Members lead the nation in effective and efficient care delivery transformation models. They also are often distinguished by their mission and work in improving population health. Members look to America's Essential Hospitals to be a source of new evidence-based ideas to support their work and to serve as a vehicle for sharing successful outcomes with each other. The work of Essential Hospitals Institute in this regard is critical, and both the institute and America's Essential Hospitals are committed to supporting members' continued innovation and adaptation. These priorities support the innovation and adaptation pillar:

Priority: America's Essential Hospitals will create a continuous learning environment for its members and serve as a convening organization and conduit for member-to-member sharing of innovative models of patient care and hospital operations, with a special emphasis on those that improve care for vulnerable populations.

Priority: America's Essential Hospitals will support its members' efforts to successfully transition to integrated, seamless, and patient-centered systems of care.

Underlying Competencies

America's Essential Hospitals has experienced organizational and programmatic growth over the past several years. Discussions during the strategic planning process identified a series of underlying competencies that cut across the strategic pillars and are vital to the association's successful implementation of the strategic plan. For America's Essential Hospitals to succeed in the priority areas identified through this strategic plan, the organization must focus on the following competencies, which are the building blocks of successful implementation.

Collaboration

America's Essential Hospitals is actively engaged in a number of dynamic collaborative relationships on behalf of its members. Collaborative efforts encompass relationships with other associations and member-driven cooperatives on advocacy and policy issues, as well as partnerships with critical stakeholders in the quality and research arena. These relationships require a significant time commitment by the CEO and senior staff. America's Essential Hospitals will continue this work and expand collaborative activities strategically.

Communication

America's Essential Hospitals understands the importance of effectively communicating both the organization's activities and the excellent work of its members. It will maintain and expand outreach efforts to policymakers, opinion leaders, other health care organizations, and the media. America's Essential Hospitals will continue its commitment to consistent and informative communications with members on a broad variety of issues, including a focus on advocacy efforts. America's Essential Hospitals also will engage members' communications staffs so it can better share information on member achievements and give members an opportunity to leverage association communications tools.

Education and Leadership Development

America's Essential Hospitals is well-known for the education programs it offers to all members, as well as its work to support the development of future health care leaders and the continued professional growth of current hospital executives. The America's Essential Hospitals Fellows Program is consistently recognized as an excellent example of the type of personal advancement the association offers to members and can serve as a model for other association leadership activities. America's Essential Hospitals will strive to develop new ways to support its member in these activities, including the use of effective distance learning methods.

Member Engagement

The financial security, effectiveness, and vibrancy of any association depend on a program of ongoing strategic membership retention and growth. America's Essential Hospitals will strategically recruit new member organizations whose missions align with the member service commitment. America's Essential Hospitals will enhance member engagement through a series of volunteer-led committees reporting to the executive committee. Additionally, the association will improve its effectiveness by broadening its contacts with the leadership and staff at member hospitals.

Research

Sound policy and practice rest on a foundation of clear evidence. America's Essential Hospitals research efforts, which often are funded and conducted through Essential Hospitals Institute, will support the quality, advocacy, and policy work of the association and the innovative adaptation work of member hospitals. America's Essential Hospitals and Essential Hospitals Institute will remain aligned to ensure members' success.

America's Essential Hospitals Mission Statement: America's Essential Hospitals champions excellence in health care for all, regardless of social or economic circumstance, and advances the work of hospitals and health systems committed to ensuring access to care and optimal health for America's most vulnerable people.

America's Essential Hospitals Members' Commitment to Service: America's Essential Hospitals members commit to providing high-quality health care to all, especially to vulnerable populations. We are innovative hospitals and health systems that constantly strive to deliver the most efficient and effective care for those in greatest need, improving patient outcomes and quality of life in the communities we serve.

Strategic Pillars			
Advocacy	Policy	Quality	Innovation & Adaptation
<p>Priorities:</p> <p>America's Essential Hospitals will advocate before Congress and the Executive Branch for the resources needed for hospitals and health systems to care for vulnerable populations – including the uninsured and underinsured – and provide essential community services, such as critical care, emergency preparedness, enabling services, public health services, and health care workforce training.</p> <p>America's Essential Hospitals will support the continued development of innovative health care delivery and the provision of integrated, seamless, patient-centered care, particularly for vulnerable patient populations, such as the elderly; the poor; those with complex medical or behavioral health or long-term care needs; the newly eligible; and the remaining uninsured.</p>	<p>Priorities:</p> <p>America's Essential Hospitals will be viewed as a national thought leader with respect to policy development on issues concerning the delivery of care to vulnerable populations and the provision of essential community services.</p> <p>America's Essential Hospitals will fully engage member hospitals and health systems in policy development work to generate strong positions and recommendations that represent the shared interests of members.</p>	<p>Priorities:</p> <p>America's Essential Hospitals will proactively identify and disseminate evidence-based best practices that will raise the quality of care for all – especially for vulnerable populations.</p> <p>America's Essential Hospitals will work tirelessly to communicate its members' quality leadership to decision-makers and opinion leaders.</p>	<p>Priorities:</p> <p>America's Essential Hospitals will create a continuous learning environment for its members and serve as a convening organization and conduit for member-to-member sharing of innovative models of patient care and hospital operations, with a special emphasis on those that improve care for vulnerable populations.</p> <p>America's Essential Hospitals will support its members' efforts to successfully transition to integrated, seamless and patient-centered systems of care.</p>

Underlying Competencies

Collaboration | Communications | Education and Leadership Development | Membership | Research



2015 Approved Budget

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2015 BUDGET JUSTIFICATION

INCOME

Membership Dues: The budget proposes \$6.61 million in membership dues under the new tiered dues structure, including six new full members (two for the full year, two at half-year, and two at quarter-year). The budget also reflects a reduction of \$266,000 as bad debt expense for the potential deactivation of four members, as 2015 will be the first year of the new dues structure.

The proposal reflects the conversion of two of the three existing associate members (Natividad and Palm Beach County) to full members. Central Health will continue as an associate member, along with one potential new recruit. Under the bylaws, associate members are other health care providers that are not general acute care providers or other health systems that are not being considered for full membership but share some characteristics with the association's full members and therefore have some similar needs.

Under the affiliate membership category, only two existing state alliances (Georgia and Florida) will continue as affiliate members. Corporate sponsors will be converted to the new "corporate affiliate" membership category. This proposed membership category, as recommended by the membership committee, will include organizations providing products and services for essential hospitals. An organization may choose to become a corporate affiliate member rather than sponsor a particular activity or event to gain year-long visibility in the association. The budget reflects the reclassification of \$80,000 from sponsorship income to membership dues.

Budgeted dues are \$1.23 million (or 23 percent) more than the 2014 projected level. Of that increase, \$285,000 is based on new 2014 members paying full-year dues in 2015, \$252,500 represents new 2015 member recruits, and \$128,000 stems from reclassification of memberships to different membership categories. In addition, \$568,000 comes from the change in dues structure.

While the budget reflects some potential deactivations, additional membership losses could occur once dues are invoiced despite the positive feedback regarding the dues change the association has received from member CEOs. We will be monitoring this item closely.

UHC Dues and Sponsorships: Under the memorandum of understanding with UHC, membership dues, sponsorships, and support to the Institute from UHC are 2 percent more than the 2014 projected and budgeted levels. UHC will also be providing a \$400,000 unrestricted grant to the Institute to help cover general and administrative costs.

In addition to UHC sponsorships, the budget reflects \$200,000 in corporate sponsorships from other organizations. This is a reduction of \$40,000 (or 17 percent) from the 2014 projected level (and 18 percent less than 2014 budget). This reduction is due to the reclassification of \$80,000 to the proposed corporate affiliate membership category, of which \$40,000 is offset by new budgeted sponsorship revenue.

Conference Registration Fees: The 2015 budget assumes \$260,000 in registration fees, of which \$151,000 is for the annual conference, VITAL2015. Included in the budget is \$34,000 in registration fees for an expanded in-person waiver meeting and \$75,000 in tuition fees for the Government Relations Academy. The 2015 budgeted fees are \$92,300 (or 55 percent) more than 2014 projected because the Government Relations Academy occurs every other year.

EXPENSES

Salaries and Fringes: Budgeted at \$4.48 million, an increase of \$530,000 (or 13 percent) from the 2014 projected level and 8 percent from the 2014 budget.

The salary and fringe line reflects a salary and merit increase pool of an average of 3.5 percent, which is consistent with other nonprofit organizations in the Washington, DC, market. It also includes three new budgeted positions- a quality/policy analyst, senior accountant, and marketing coordinator.

The new quality/policy analyst will track hospital quality measures at the National Quality Forum (NQF), support Bruce Siegel in his role on the NQF board, and handle performance incentive programs, including the Hospital Value-Based Purchasing Program, the Hospital Readmissions Reduction Program, and the Hospital Acquired Conditions Program. This position will be the key point person working with the Centers for Disease Control and Prevention, The Joint Commission, and other stakeholders on quality-related policy issues. At this time, America's Essential Hospitals is the only national hospital association without a dedicated quality/policy staff person.

The senior accountant position—funded from the Partnership for Patients, Essential Hospitals Engagement Network (EHEN) contract—will oversee the EHEN contract, track expenditures, and monitor the budget. This previously budgeted position was filled and vacated earlier this year and replaced with a junior-level staff accountant. The finance team recognizes a need for a higher-level accounting professional to oversee the EHEN contract while the junior-level position handles the day-to-day accounting functions.

The marketing coordinator position will assist staff as they handle the expanded volume of programs and events. Duties will include the Gage Awards Program, membership recruitment, and speaker management for association and Institute events.

The budget reflects a 25 percent increase in health insurance premiums that was recently assessed by Carefirst and 10 percent increases in other insurance benefits. Total budgeted salary and fringe costs for the association and Institute is \$8.5 million, of which \$4 million is allocated to the Institute. The allocation split in the 2015 budget is approximately the same (50/50) as the 2014 projection.

Support to Institute: Budgeted at \$595,000, this line reflects the budgeted uncovered salary, fringe, and programmatic costs for Institute staff working on research and analytics work.

Policy: Budgeted at \$294,000, an increase of \$26,000 (or 10 percent) from the 2014 projected level and 19 percent more than the 2014 budget.

The increase in budgeted costs is primarily due to outsourcing of sophisticated quantitative analysis and analytical modeling to KNG Health and The Moran Company (for \$190,000). The increase in this line item recognizes an expected need for analysis of regulatory and legislative proposals. The budget also includes a retainer with Health Policy Alternatives (of \$42,000) for the drafting of special bulletins, comment letters, and policy briefs. The amicus briefs budget (of \$25,000) was increased by \$5,000, as staff anticipates legal action related to the 340B Drug Pricing Program and ongoing efforts relating to challenges to the Affordable Care Act. An in-person advisory committee meeting (\$17,000) and outside conferences and meetings (\$13,000) were budgeted at the same level as 2014.

Advocacy: Budgeted at \$653,000, an increase of \$191,200 (or 41 percent) from the 2014 projected level, and an increase of \$197,000 (43 percent) from the 2014 budget.

The budget includes the hosting of two policy assembly events (\$244,000); Holland & Knight LLP retainer fees (\$156,000) for general advocacy services; Schrayer and Associates consulting services (\$40,000); site visits and outside meetings (\$27,000); and dues, subscriptions, licenses, and webinars (\$43,000). The increase from the 2014 projection and budget is due to the reclassification of the Coalition to Protect America's Healthcare contribution (of \$50,000) from the communications budget line to advocacy and higher budgeted speaker fees and food costs for the policy assembly meetings. Furthermore, the budget reflects \$94,300 for the Government Relations Academy, a new expense for 2015 since this program occurs every other year.

Member Services: Budgeted at \$244,700, a reduction of \$4,500 (2 percent) from the 2014 projected amount, an increase of \$12,200 (5 percent) from the 2014 budget.

The budget reflects site visits for membership recruitment and retention activities (\$50,000), awards and education committee expenses (\$30,000), membership materials and mailings (\$16,000), sponsorships to other organizations (\$138,000), and conference site visit travel (\$10,000). The membership committee is not scheduled to meet in person, as the bulk of their work was completed in 2014 and no new initiatives are planned for 2015.

Conferences: Budgeted expenses of \$637,000, an increase of \$183,000 (or 40 percent) from the 2014 projected amount and 4 percent from the 2014 budget.

Budgeted conferences and meetings include the VITAL2015 annual conference (\$427,200 in expenses), fall innovations summit (\$51,000), governance meetings (\$125,000), and a waiver summit (\$33,800). The board governance meetings will continue to be held in conjunction with a major event (spring and fall policy assemblies and VITAL2015). Bundled 2015 events will be scheduled three times during the year: March, June, and fall.

The increase from 2014 is due to the following assumptions:

- Budgeted food costs for VITAL2015 are 30 percent (\$100,000) higher than VITAL2014 due to the San Diego location and a projected 50-person increase in attendees (budgeted at \$29,000).
- The budgeted cost of 2015 governance meetings is higher than the 2014 projected amount (by \$44,000) because the budget assumes full board attendance at the three planned board meetings and includes a new strategic planning committee meeting.
- The waiver summit assumes increased attendees in 2015.

Communications: Budgeted at \$231,000, a reduction of \$52,700 (or 19 percent) from the 2014 projected amount and a 25 percent decrease from the 2014 budget.

Budgeted costs are less than the 2014 projection and budget because of the reclassification of the Coalition to Protect America's Healthcare contribution (of \$50,000) to the advocacy line.

The 2015 communications budget maintains the association's relationship with Neimand Collaborative (at \$50,000) as primary consultant for creative direction on advocacy and other campaigns. In 2015, staff expect to renew a campaign to ensure sufficient and sustainable

funding for essential hospitals. The budget includes ongoing website support (at \$58,000); branding, design work, and publications (at \$31,000); dues and subscriptions (at \$20,400) for social media management and various services, associations, and publications relevant to communications work; media and advertising campaigns (at \$53,500); and \$12,000 for a robust media monitoring and tracking service and materials for a new media library and electronic magazine (ezine).

Consulting/Professional Fees: Budgeted at \$117,500, a decrease of \$4,500 (or 4 percent) from the 2014 projected amount and 13 percent from the 2014 budget.

Included in this line are auditing and 990 tax return fees (\$30,000), recruitment and human resource consulting fees (\$42,500), legal fees for non-retainer related issues (\$23,000), and unspecified consulting services (\$22,000).

This budget line does not reflect an exhaustive list of 2015 consultants. Consulting costs for policy and advocacy are reflected in their own budget lines, writers and other public relations consultants are budgeted in communications, member services consultants are budgeted in member services, and computer consultants are reflected in the information technology (IT) line.

Retainer: Budgeted at \$350,000, a reduction of \$50,000 (or 13 percent) from 2014.

As a result of cutting back on the retainer, America's Essential Hospitals will utilize internal staff to handle policy development work, including writing comment letters, tracking issues, and responding to requests for information.

IT: Budgeted at \$111,300, a decrease of \$9,700 (or 8 percent) from the 2014 projected amount and 2 percent less than the 2014 budget.

Included in this budget line are the costs associated with the hiring of computer consultants (\$21,000), support agreements and licenses (\$14,300), membership database consultants and fees (\$42,000), cloud fees (\$18,500), and computer supplies (\$15,500).

In addition to the \$111,300 reflected in the association budget, \$69,300 in shared IT costs is reflected in the Institute's budget.

Rent: Budgeted at \$385,000, an increase of \$9,000 (or 2 percent) from the 2014 projected amount and the same as the 2014 budget.

The budget reflects a 2 percent increase to the base rent for the advocacy, policy, communications, member services, and finance and administrative staff. The rent for the suite housing the Institute staff is reflected in the institute's budget (an additional \$354,000). The office relocation is anticipated to occur in mid-December.

Office Expenses and Equipment Rental: Budgeted at \$212,500, an increase of \$29,400 (or 16 percent) from the 2014 projected amount and 5 percent less than the 2014 budget.

This budgeted line item reflects general office expenses, including telephone, supplies, advertising and recruitment, dues and subscriptions, temporary help, and printing expenses. This line also includes leasing fees associated with the copiers and telephone system (totaling \$53,000). The increase from the 2014 projected amount is due to a new \$20,000 expense for an

e-scanning service to eliminate paper financial and human resource documents before the office move.

Travel and Professional Development: Budgeted at \$180,000, an increase of \$52,500 (or 41 percent) from the 2014 projected amount and 43 percent from the 2014 budget.

The significant change in this line item is due to increased staff professional development opportunities to include continuing education and professional certification classes, new staff training initiatives, a one-night site visit for 15 staff to visit a member hospital, licenses for online professional development videos, and budgeted training opportunities as recommended by the leadership team. The budget also assumes a 10 percent increase in travel costs relating to staff airfare, food, and hotel expenses.

Taxes/Insurance/Miscellaneous: Budgeted at \$87,000, an increase of \$18,000 (or 26 percent) from the 2014 projected amount and budget.

Budgeted line item costs include general liability, commercial and Director's and Officer's insurance (\$28,600); bank and credit card processing fees (\$13,000); a bank line of credit fee (\$15,000); administrative fees for employee benefit plans (\$15,000); a web-based third-party payable administrator (\$7,800); and licenses and property and use taxes (\$7,500). The budgeted increase is for higher line of credit bank fees associated with the move.

Depreciation/Amortization: Budgeted at \$157,000, an increase of \$126,400 from the 2014 projected amount and 108 percent more than the 2014 budget.

The significant change in this line item is due to the reclassification of \$93,000 in depreciation for the new website from the rebranding line funded from reserves to an ongoing expense funded from operations.

The 2015 fixed asset budget (of \$63,500) includes costs for new computer hardware and software programs and office enhancements, which are depreciable over a three-year period. Furniture and equipment costs for the move are reflected in the move budget, which will be funded from reserves.

Project Development: Budgeted at \$100,000, no change from 2014.

As additional funding resources are sought, a fund of \$100,000 has been budgeted at the same level as the 2014 budget to support consultants to evaluate the risk and returns for new business proposals.

Office Move (Funded from Reserves): Budgeted at \$435,000.

Included in this line are the nondepreciable and nonamortizable moving costs that will be expensed in 2015 (e.g., moving services, architectural and engineering fees, furniture consultants, new copier lease, stationary, kitchen and office supplies)

Attachment I

2014 Projection and 2015 Proposed Budget

	col 1 2014 Revised Budget	col 2 2014 Fall Projection	col 5 2015 Proposed Budget	col 6 fav/(unfav.) 2015 vs 2014 proj	col 6 fav/(unfav.) 2015 vs '14 proj % change	col 7 2015 vs 2014 budget	col 7 2015 vs '14 budget % change
REVENUE:							
Membership Dues	\$ 5,153,100	\$ 5,379,800	\$ 6,612,000	\$ 1,232,200	23%	\$ 1,458,900	28%
UHC Membership Dues and Sponsorships	\$ 3,150,000	\$ 3,150,000	\$ 3,170,000	\$ 20,000	1%	\$ 20,000	1%
Other sponsorships	\$ 245,000	\$ 240,000	\$ 200,000	\$ (40,000)	-17%	\$ (45,000)	-18%
Conferences	\$ 162,200	\$ 167,700	\$ 260,000	\$ 92,300	55%	\$ 97,800	60%
Publication Sales/Misc.	\$ -	\$ 3,500	\$ -	\$ (3,500)	-100%	\$ -	100%
TOTAL REVENUE	\$ 8,710,300	\$ 8,941,000	\$ 10,242,000	\$ 1,301,000	15%	\$ 1,531,700	18%
EXPENSE:							
Personnel Labor & Fringes	\$ 4,140,000	\$ 3,950,000	\$ 4,480,000	\$ (530,000)	-13%	\$ (340,000)	-8%
Contribution /Support to Institute	\$ -	\$ -	\$ 595,000	\$ (595,000)	100%	\$ (595,000)	100%
Policy	\$ 246,700	\$ 268,000	\$ 294,000	\$ (26,000)	-10%	\$ (47,300)	-19%
Advocacy	\$ 456,000	\$ 461,800	\$ 653,000	\$ (191,200)	-41%	\$ (197,000)	-43%
Member Services	\$ 232,500	\$ 249,200	\$ 244,700	\$ 4,500	2%	\$ (12,200)	-5%
Conferences	\$ 612,200	\$ 454,000	\$ 637,000	\$ (183,000)	-40%	\$ (24,800)	-4%
Communications	\$ 307,600	\$ 283,700	\$ 231,000	\$ 52,700	19%	\$ 76,600	25%
Consulting/Prof Fees	\$ 135,000	\$ 122,000	\$ 117,500	\$ 4,500	4%	\$ 17,500	13%
Retainer	\$ 400,000	\$ 400,000	\$ 350,000	\$ 50,000	13%	\$ 50,000	13%
Information Technology	\$ 114,000	\$ 121,000	\$ 111,300	\$ 9,700	8%	\$ 2,700	2%
Rent	\$ 384,200	\$ 376,000	\$ 385,000	\$ (9,000)	-2%	\$ (800)	0%
Office expenses/equipment rental	\$ 223,100	\$ 183,100	\$ 212,500	\$ (29,400)	-16%	\$ 10,600	5%
Travel and Prof Development	\$ 125,500	\$ 127,500	\$ 180,000	\$ (52,500)	-41%	\$ (54,500)	-43%
Taxes, Insurance and Misc.	\$ 69,000	\$ 69,000	\$ 87,000	\$ (18,000)	-26%	\$ (18,000)	-26%
Depreciation/Amortization	\$ 75,500	\$ 30,600	\$ 157,000	\$ (126,400)	-413%	\$ (81,500)	-108%
Project Development	\$ 100,000	\$ 100,000	\$ 100,000	\$ -	0%	\$ -	0%
TOTAL EXPENSE	\$ 7,621,300	\$ 7,195,900	\$ 8,835,000	\$ (1,639,100)	-23%	\$ (1,213,700)	-16%
Changes in Net Assets before funding from reserves	\$ 1,089,000	\$ 1,745,100	\$ 1,407,000	\$ 2,940,100		\$ 2,745,400	
Other Items funded from Reserves:							
Rebranding (including depreciation on website)	\$ (100,000)	\$ (93,000)	\$ -	\$ 93,000		\$ 100,000	
Office Move	\$ (212,000)	\$ (60,000)	\$ (435,000)	\$ (375,000)		\$ (223,000)	
Changes in Net Assets, after funding from reserves (operating surplus) & before non-operating income	\$ 777,000	\$ 1,592,100	\$ 972,000	\$ 2,658,100		\$ 2,622,400	
Non-Operating Income:							
Interest/Dividend Income	\$ 50,000	\$ 20,000	\$ -	\$ (20,000)		\$ (50,000)	
Realized Capital Gains/(Losses)	\$ -	\$ 559,000	\$ -	\$ (559,000)		\$ -	
Unrealized Gains/(Losses)	\$ -	\$ (450,000)	\$ -	\$ 450,000		\$ -	
Total Non-Operating Income/(Loss)	\$ 50,000	\$ 129,000	\$ -	\$ (129,000)		\$ (50,000)	
Changes in Net Assets, after Non-Operating Income	\$ 827,000	\$ 1,721,100	\$ 972,000	\$ 2,529,100		\$ 2,572,400	

Attachment I

2014 Projection and 2015 Proposed Budget

(continued)

	2014 Revised Budget	2014 Fall Projection	2015 Proposed Budget	2015 vs 2014 proj	2015 vs '14 proj % change	2015 vs 2014 budget	2015 vs '14 budget % change
NET ASSETS:							
Prior Year Net Assets	\$ 6,759,350	\$ 6,759,350	\$ 8,480,450	\$ 1,721,100		\$ 1,721,100	
Change in Net Assets	\$ 827,000	\$ 1,721,100	\$ 972,000	\$ (749,100)		\$ 145,000	
Total Net Assets after funding of special projects	\$ 7,586,350	\$ 8,480,450	\$ 9,452,450	\$ 972,000	\$ -	\$ 1,866,100	\$ -
Contribution to Restricted Net Assets:							
Office Relocation (restricted net assets)	\$ (100,000)	\$ (200,000)	\$ -	\$ 200,000		\$ 100,000	
Total Contribution to Restricted Net Assets	\$ (100,000)	\$ (200,000)	\$ -	\$ 200,000	\$ -	\$ 100,000	\$ -
Summary of Total Net Assets:							
Unrestricted Net Assets	\$ 7,236,350	\$ 8,030,450	\$ 9,002,450	\$ 972,000		\$ 1,766,100	
Restricted Net Assets for office relocation	\$ 350,000	\$ 450,000	\$ 450,000	\$ -		\$ 100,000	
Total Net Assets	\$ 7,586,350	\$ 8,480,450	\$ 9,452,450	\$ 972,000	\$ -	\$ 1,866,100	\$ -



September 2014

America's Essential Hospitals: Our Advocacy Achievements

As the only national organization representing hospitals dedicated to caring for the vulnerable, America's Essential Hospitals is your voice in Washington. We represent your interests in legislative and regulatory actions that impact hospitals and health systems like yours.

As an advocate and partner, America's Essential Hospitals supports your work to deliver exceptional care to all and improve community health. We support our members' innovative efforts to transform hospital care and lead the charge for equitable compensation in current and emerging payment and delivery systems. We are fighting—and winning—for you in Washington. Here are some of our accomplishments on your behalf:

Fighting Federal Cuts to Medicaid

America's Essential Hospitals successfully delayed Affordable Care Act (ACA) cuts to Medicaid disproportionate share hospital (DSH) payments for fiscal years 2014, 2015, and 2016, saving essential hospitals \$1.7 billion over these years. We also won establishment of a mandatory annual report on levels of uninsured and uncompensated care to provide policymakers with an evidence base to make the case for future DSH funding.

Fostering Innovation in Medicaid Delivery

America's Essential Hospitals supports members' understanding of and participation in Medicaid delivery system reform incentive program (DSRIP) waivers. Further, we promote information sharing among members and between members and key staff of the Centers for Medicare & Medicaid Services (CMS). Educational components have included extensive onsite programming at our annual

conference, a dedicated waiver summit, numerous distance learning opportunities, and research and policy briefs.

Ensuring Equity in Incentive Programs

We strongly advocate for socioeconomic risk adjustment in federal performance incentive programs, such as the Medicare Readmissions Reduction Program. We work closely with the National Quality Forum and other stakeholders to reduce the potential for such programs to penalize essential hospitals for factors outside their control.

Realizing the Promise of Coverage Expansion

We are a diligent champion for access to hospital and health care and have worked to help realize the ACA's promise of broadly expanded health care coverage. In our leadership role with the Partnership for Medicaid, a coalition of providers and health plans, we have organized Capitol Hill briefings on coverage expansion, developed proposals to ensure care quality in Medicaid, and provided important perspectives to policymakers.

Ensuring Access to Outpatient Care

America's Essential Hospitals shielded members from site neutral Medicare payment reductions, such as cuts to outpatient evaluation and management services recommended by the Medicare Payment Advisory Commission and considered by Congress as part of deficit reduction and other legislation.

Protecting the 340B Drug Pricing Program

We advocated strongly for 340B and its benefits to low-income patients and the providers who serve

them. Despite substantial congressional scrutiny of 340B, no legislation to make substantive changes to the program has advanced beyond introduction.

Preserving ACA Marketplace Participation

Responding to reports that qualified health plans in the ACA marketplace use various means to exclude member hospitals from provider networks, America's Essential Hospitals gathered data for a successful campaign to improve member participation in these plans. Our advocacy enhanced federal network adequacy requirements by increasing the mandatory percentage of essential community providers that plans must include.

Leading on Health Care in Key Social Issues

We advance members' interests in immigration reform by highlighting the need to bring health care issues into the debate—specifically allowing immigrants to access coverage more quickly. America's Essential Hospitals also developed principles on violence prevention and mental health and advocated for enhanced access to mental health services for vulnerable people.

Raising the Visibility of Essential Hospitals

America's Essential Hospitals stands as the nation's foremost expert and trusted source on Medicaid and hospital care for vulnerable populations. Its brand underscores why communities must continue to invest in essential hospitals, even with increasing coverage under health care reform. Through proactive media campaigns, the association educates the nation about essential health systems and their patients. We also work with member hospitals to make their voices heard in local and national reports on hospitals and health care.

Learn More

Learn more about our work in Washington on behalf of essential hospitals and their patients. Visit essentialhospitals.org or contact us at GOV.admin@essentialhospitals.org or 202-585-0100.



Senior Leadership

Bruce Siegel, MD, MPH President and CEO

Since joining America's Essential Hospitals in 2010, Siegel has used his extensive background in health care management, policy, and public health to achieve the association's strategic vision of its members as integrated delivery systems and leaders in access and quality.

He served previously as Center for Health Care Quality director and health policy professor at the George Washington University School of Public Health and Health Services. Before that, Siegel was president and CEO of two member systems: Tampa General Healthcare and the New York City Health and Hospitals Corporation. He also served as New Jersey's commissioner of health.

Among his many accomplishments, Siegel led groundbreaking work on quality and equity for the Robert Wood Johnson Foundation. Modern Healthcare named him one of the “100 Most Influential People in Healthcare” in 2011, 2012, and 2013, and one of the “50 Most Influential Physician Executives” in 2012 and 2013. Currently, he chairs the National Advisory Council for Healthcare Research and Quality and is a member of the National Quality Forum board of directors.

Beth Feldpush, DrPH Senior Vice President of Policy and Advocacy

Feldpush oversees advocacy, policy, and communications work for America's Essential Hospitals. In this role, she provides strategic leadership and advocacy on behalf of safety net health systems. Feldpush directs the association's federal government affairs portfolio, as well as the organization's policy development activities. She oversees the association's internal and external communications efforts. Feldpush also manages the association's participation in and leadership of coalitions and allied organization activities, acting as a liaison to other trade associations.

Feldpush previously served as a senior associate director for policy at the American Hospital Association (AHA), where she worked on health care delivery system reform and hospital quality and patient safety issues. Prior to joining AHA, Feldpush worked at the U.S. Government Accountability Office, where her work focused on Medicare payment policy, end-of-life care, geographic variation in service delivery, and health

care workforce adequacy. She also serves as adjunct faculty for the George Washington University School of Public Health Department of Health Policy.

David Engler, PhD

Senior Vice President of Leadership and Innovation

Engler joined America's Essential Hospitals in June 2013 and provides vision, strategic direction, and oversight for activities supporting its members as they transform into integrated health systems that deliver quality and access to the most vulnerable populations.

His experience lies in quality improvement and safety initiatives in the health care industry. He also is nationally recognized for performance improvement and clinical informatics solutions that lead to improved outcomes and reduced harm. Engler previously held the position of vice president at the Ohio Hospital Association, in Columbus, Ohio, where he led the association's strategic initiatives in quality and safety.

Engler received a BS in natural sciences from Case Western Reserve University, in Cleveland, and an MS in preventative medicine and PhD in economics, both from Ohio State University.

Kristine Metter

Vice President of Member Services

Kristine Metter has worked in the nonprofit and association industry for more than 20 years, primarily in the health care arena. At America's Essential Hospitals, she spearheads membership recruitment and engagement, as well as association meetings.

Before joining America's Essential Hospitals, Metter was vice president of administration and operations for the Visiting Nurse Associations of America, a vice president for AcademyHealth, and director of membership for the National Association of Student Personnel Administrators. She is a certified association executive (CAE) and holds a master's degree in nonprofit management from the University of Maryland University College and a BSBA in marketing from the University of Missouri.

Rhonda Gold, CPA

Chief Financial Officer

Rhonda Gold has been employed with Essential Hospitals Institute (formerly the National Public Health and Hospital Institute) since 1992. She has more than 25 years of accounting experience and is a certified public accountant. Her primary responsibilities include providing oversight and managing of all finance, information technology, human resources, and operational functions of America's Essential Hospitals and the Institute.

Before joining the organization, Gold was the assistant controller at a large employment agency, an accounting manager for two property management companies, an auditor for Marriott Corp., and an auditor for a large public accounting firm. She graduated on the dean's list from the University of Maryland with a bachelor of science degree.



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Denver Conf Rm Phone:	202.585.0557
Harris Conf Rm Phone:	202.495.3348

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Loading Dock:	202.662.1200
Emergency/Rescue:	911
Bldg Mgr./Quadrangle:	202.662.1200



Membership List

Alabama

East Alabama Medical Center (Opelika, AL)

East Alabama Medical Center, Lanier (Valley, AL)

University of Alabama at Birmingham (UAB Health System) (Birmingham, AL)

Callahan Eye Hospital (Birmingham, AL)

Spain Rehabilitation Center (Birmingham, AL)

UAB Hospital (Birmingham, AL)

UAB Hospital-Highlands (Birmingham, AL)

Women & Infants Center (Birmingham, AL)

University of South Alabama Medical Center (Mobile, AL)

University of South Alabama Children's and Women's Hospital (Mobile, AL)

Arizona

Banner Health (Tucson, AZ)

Banner University Medical Center South (Tucson, AZ)

Banner University Medical Center Tucson (Tucson, AZ)

Maricopa Integrated Health System (MIHS) (Phoenix, AZ)

Maricopa Medical Center (Phoenix, AZ)

Arkansas

University of Arkansas for Medical Sciences (UAMS) (Little Rock, AR)

California

Alameda Health System (Oakland, CA)

Alameda Hospital (Alameda, CA)

Fairmont Hospital (San Leandro, CA)

Highland Hospital (Oakland, CA)

John George Psychiatric Hospital (San Leandro, CA)

San Leandro Hospital (Oakland, CA)

Arrowhead Regional Medical Center (Colton, CA)

City and County of San Francisco Department of Public Health (San Francisco, CA)

Laguna Honda Hospital and Rehabilitation Center (San Francisco, CA)

San Francisco General Hospital and Trauma Center (San Francisco, CA)

Contra Costa Health Services (Martinez, CA)

Contra Costa Regional Medical Center (Martinez, CA)

Kern Medical Center (Bakersfield, CA)

Los Angeles County Department of Health Services (Los Angeles, CA)

Harbor-UCLA Medical Center (Torrance, CA)

High Desert Regional Health Center (Lancaster, CA)

LAC+USC Medical Center (Los Angeles, CA)

Olive View-UCLA Medical Center (Sylmar, CA)

Rancho Los Amigos National Rehabilitation Center (Downey, CA)

Natividad Medical Center (Salinas, CA)

Riverside County Regional Medical Center (Moreno Valley, CA)

San Joaquin General Hospital (French Camp, CA)

San Mateo Medical Center (San Mateo, CA)

Santa Clara Valley Health & Hospital System (San Jose, CA)

Santa Clara Valley Medical Center (San Jose, CA)

University of California (Oakland, CA)

Mattel Children's Hospital UCLA (Los Angeles, CA)

Resnick Neuropsychiatric Hospital at UCLA (Los Angeles, CA)

Ronald Reagan UCLA Medical Center (Los Angeles, CA)

Shiley Eye Center (San Diego, CA)

UC Davis Medical Center (Sacramento, CA)

UC Irvine Medical Center (Orange, CA)

UCLA Medical Center Santa Monica (Santa Monica, CA)

UCSD Medical Center (San Diego, CA)

UCSD Thornton (San Diego, CA)

UCSF Benioff Children's Hospital (San Francisco, CA)

UCSF Medical Center at Mount Zion (San Francisco, CA)

Ventura County Health Care Agency (Ventura, CA)

Santa Paula Hospital (Santa Paula, CA)

Ventura County Medical Center (Ventura, CA)

Colorado

Denver Health (Denver, CO)

District of Columbia

Howard University Hospital (Washington, DC)

United Medical Center (Washington, DC)

Florida

Broward Health (Fort Lauderdale, FL)

Broward Health Coral Springs (Coral Springs, FL)

Broward Health Imperial Point (Fort Lauderdale, FL)

Broward Health Medical Center (Fort Lauderdale, FL)

Broward Health North (Deerfield Beach, FL)

Chris Evert Children's Hospital (Fort Lauderdale, FL)

Halifax Health (Daytona Beach, FL)

Halifax Health Medical Center (Daytona Beach, FL)

Halifax Health Medical Center Port Orange (Port Orange, FL)

Health Care District of Palm Beach County (Palm Springs, FL)

Lakeside Medical Center (Belle Glade, FL)

Jackson Health System (Miami, FL)

Holtz Children's Hospital (Miami, FL)

Jackson Behavioral Health Hospital (Miami, FL)

Jackson Memorial Hospital (Miami, FL)

Jackson North Medical Center (Miami, FL)

Jackson Rehabilitation Hospital (Miami, FL)

Jackson South Community Hospital (Miami, FL)

Lee Memorial Health System (Fort Myers, FL)

Cape Coral Hospital (Cape Coral, FL)

Golisano Children's Hospital of Southwest Florida (Fort Myers, FL)

Gulf Coast Medical Center (Fort Myers, FL)

HealthPark Medical Center (Fort Myers, FL)

Lee Memorial Hospital (Fort Myers, FL)

The Rehabilitation Hospital (Fort Myers, FL)

Memorial Healthcare System (Hollywood, FL)

Joe DiMaggio Children's Hospital (Hollywood, FL)

Memorial Hospital Miramar (Miramar, FL)

Memorial Hospital Pembroke (Pembroke Pines, FL)

Memorial Hospital West (Pembroke Pines, FL)

Memorial Regional Hospital (Hollywood, FL)
Memorial Regional Hospital South (Hollywood, FL)

Orlando Health (Orlando, FL)

Arnold Palmer Hospital for Children (Orlando, FL)
Dr. P. Phillips Hospital (Orlando, FL)
Health Central Hospital (Orlando, FL)
Orlando Regional Medical Center (Orlando, FL)
South Lake Hospital (Clermont, FL)
South Seminole Hospital (Longwood, FL)
Winnie Palmer Hospital for Women and Babies (Orlando, FL)

Tampa General Hospital (Tampa, FL)

University of Florida Health (Gainesville, FL)

UF Health Jacksonville (Jacksonville, FL)
UF Health Shands Children's Hospital (Gainesville, FL)
UF Health Shands Hospital (Gainesville, FL)
UF Health Shands Psychiatric Hospital (Gainesville, FL)
UF Health Shands Rehab Hospital (Gainesville, FL)

Georgia

Grady Health System (Atlanta, GA)

Grady Memorial Hospital (Atlanta, GA)
Lindbergh Women's & Children's Center (Atlanta, GA)

Idaho

St. Luke's Health System (Boise, ID)

St. Luke's Children's Hospital (Boise, ID)
St. Luke's Elmore Medical Center (Mountain Home, ID)
St. Luke's Jerome (Jerome, ID)
St. Luke's Magic Valley Medical Center (Twin Falls, ID)
St. Luke's McCall Medical Center (McCall, ID)
St. Luke's Meridian Medical Center (Meridian, ID)
St. Luke's Regional Medical Center (Boise, ID)
St. Luke's Wood River Medical Center (Ketchum, ID)

Illinois

Cook County Health & Hospitals System (Chicago, IL)

John H. Stroger, Jr. Hospital of Cook County (Chicago, IL)
Oak Forest Hospital of Cook County (Oak Forest, IL)
Provident Hospital of Cook County (Chicago, IL)

Norwegian American Hospital (Chicago, IL)

Presence Health (Chicago, IL)

Presence Mercy Medical Center (Aurora, IL)
Presence Saints Mary and Elizabeth Medical Center, Saint Elizabeth Campus (Chicago, IL)

Swedish Covenant Hospital (Chicago, IL)

University of Chicago Medicine (Chicago, IL)

Bernard Mitchell Hospital (Chicago, IL)
Comer Children's Hospital (Chicago, IL)

University of Illinois Hospital & Health Sciences System (Chicago, IL)

Indiana

Health and Hospital Corporation of Marion County (Indianapolis, IN)

Sidney and Lois Eskenazi Hospital (Indianapolis, IN)

Iowa

Broadlawns Medical Center (Des Moines, IA)

Kansas

The University of Kansas Hospital (Kansas City, KS)

Kentucky

UK HealthCare (Lexington, KY)

Kentucky Children's Hospital (Lexington, KY)
UK Albert B. Chandler Hospital (Lexington, KY)
UK Good Samaritan Hospital (Lexington, KY)

Louisiana

Interim LSU Hospital (New Orleans, LA)

Maryland

Bon Secours Hospital (Baltimore, MD)

Massachusetts

Boston Medical Center (Boston, MA)

Cambridge Hospital Campus (Cambridge, MA)

Somerville Hospital Campus (Somerville, MA)
Whidden Hospital Campus (Cambridge, MA)

UMass Memorial Health Care (Worcester, MA)

Clinton Hospital (Clinton, MA)
Health Alliance Hospitals (Leominster, MA)
Marlborough Hospital (Marlborough, MA)
UMass Memorial Medical Center-University Campus (Worcester, MA)

Michigan

Henry Ford Health System (Bingham Farms, MI)

Henry Ford Hospital (Detroit, MI)

Henry Ford Kingswood Hospital (Ferndale, MI)

Henry Ford Macomb Hospital (Clinton Township, MI)

Henry Ford Macomb Hospital-Mt. Clemens Campus (Warren, MI)

Henry Ford Macomb Physical Rehabilitation Center (Warren, MI)

Henry Ford West Bloomfield Hospital (West Bloomfield, MI)

Henry Ford Wyandotte Hospital (Wyandotte, MI)

Hurley Medical Center (Flint, MI)

Minnesota

Hennepin County Medical Center (Minneapolis, MN)

Regions Hospital (Saint Paul, MN)

Mississippi

University of Mississippi Health Care (Jackson, MS)

Batson Children's Hospital (Jackson, MS)

Holmes County Hospital and Clinics (Lexington, MS)

University of Mississippi Medical Center (Jackson, MS)

Wallace R. Connerly Critical Care Hospital (Jackson, MS)

Winfred L. Wiser Hospital for Women and Infants (Jackson, MS)

Missouri

Truman Medical Centers (Kansas City, MO)

TMC Behavioral Health (Kansas City, MO)

TMC Hospital Hill (Kansas City, MO)

TMC Lakewood (Kansas City, MO)

University of Missouri Health Care (Columbia, MO)

Missouri Psychiatric Center (Columbia, MO)

The Missouri Orthopaedic Institute (Columbia, MO)

University Hospital (Columbia, MO)

University of Missouri Women's and Children's Hospital (Columbia, MO)

Nevada

University Medical Center of Southern Nevada (Las Vegas, NV)

Children's Hospital of Nevada at UMC (Las Vegas, NV)

New Jersey

LibertyHealth/Jersey City Medical Center (Jersey City, NJ)

University Hospital (Newark, NJ)

New Mexico

UNM Health Sciences Center (Albuquerque, NM)

UNM Carrie Tingley Hospital (Albuquerque, NM)
UNM Children's Hospital (Albuquerque, NM)
UNM Children's Psychiatric Center (Albuquerque, NM)
UNM Hospital (Albuquerque, NM)
UNM Psychiatric Center (Albuquerque, NM)
UNM Sandoval Regional Medical Center (Rio Rancho, NM)

New York

Erie County Medical Center (Buffalo, NY)

New York City Health and Hospitals Corporation (New York, NY)

Bellevue Hospital Center (New York, NY)
Coler-Goldwater Specialty Hospital and Nursing Facility (Coler Campus) (New York, NY)
Coler-Goldwater Specialty Hospital and Nursing Facility (Goldwater Campus) (New York, NY)
Coney Island Hospital (Brooklyn, NY)
Dr. Susan Smith McKinney Nursing and Rehabilitation Center (Brooklyn, NY)
Elmhurst Hospital Center (Elmhurst, NY)
Gouverneur Healthcare Services (New York, NY)
Harlem Hospital Center (New York, NY)

Henry J. Carter Specialty Hospital & Nursing Facility (New York, NY)

Jacobi Medical Center (Bronx, NY)

Kings County Hospital Center (Brooklyn, NY)

Lincoln Medical and Mental Health Center (Bronx, NY)

Metropolitan Hospital Center (New York, NY)

North Central Bronx Hospital (Bronx, NY)

Queens Hospital Center (Jamaica, NY)

Sea View Hospital Rehabilitation Center and Home (Staten Island, NY)

Woodhull Medical and Mental Health Center (Brooklyn, NY)

NuHealth (East Meadow, NY)

SUNY- State University of New York (Brooklyn, NY)

Stony Brook University Hospital (Stony Brook, NY)

SUNY Downstate Medical Center (Brooklyn, NY)

SUNY Upstate Medical University (Syracuse, NY)

Westchester Medical Center (Valhalla, NY)

MidHudson Regional Hospital of Westchester (Poughkeepsie, NY)

North Carolina

CaroMont Health (Gastonia, NC)

Ohio

The MetroHealth System (Cleveland, OH)

MetroHealth Medical Center-Main Campus (Cleveland, OH)

The Ohio State University Wexner Medical Center (Columbus, OH)

OSU Harding Hospital (Columbus, OH)
Richard M. Ross Heart Hospital (Columbus, OH)
University Hospital (Columbus, OH)
University Hospital East (Columbus, OH)

UC Health (Cincinnati, OH)

Oklahoma

Oklahoma State University Medical Center (Tulsa, OK)

Pennsylvania

Einstein Healthcare Network (Philadelphia, PA)

Einstein Medical Center Elkins Park (Elkins Park, PA)
Einstein Medical Center Montgomery (East Norriton, PA)
Einstein Medical Center Philadelphia (Philadelphia, PA)
MossRehab (Elkins Park, PA)

Temple University Health System (Philadelphia, PA)

Episcopal Hospital (Philadelphia, PA)
Jeanes Hospital (Philadelphia, PA)
Temple University Hospital (Philadelphia, PA)

Rhode Island

Care New England Health System (Providence, RI)

Butler Hospital (Providence, RI)
Kent Hospital (Warwick, RI)
Memorial Hospital of Rhode Island (Pawtucket, RI)
Women & Infants Hospital of Rhode Island (Providence, RI)

Rhode Island Hospital (Providence, RI)

Hasbro Children's Hospital (Providence, RI)

South Carolina

MUSC Medical University of South Carolina (Charleston, SC)

Tennessee

Erlanger Health System (Chattanooga, TN)

Children's Hospital at Erlanger (Chattanooga, TN)

Erlanger Baroness Campus (Chattanooga, TN)

Erlanger Bledsoe Campus (Pikeville, TN)

Erlanger East Campus (Chattanooga, TN)

Erlanger North Campus (Chattanooga, TN)

Nashville General Hospital at Meharry (Nashville, TN)

Regional One Health (Memphis, TN)

Texas

Central Health (Austin, TX)

Harris Health System (Houston, TX)

Ben Taub General Hospital (Houston, TX)

Lyndon Baines Johnson General Hospital (Houston, TX)

Quentin Mease Hospital (Houston, TX)

JPS Health Network (Fort Worth, TX)

John Peter Smith Hospital (Fort Worth, TX)

Parkland Health & Hospital System (Dallas, TX)

The University of Texas Medical Branch (Galveston, TX)

Children's Hospital (Galveston, TX)

Jennie Sealy Hospital (TBC in 2015) (Galveston, TX)

John Sealy Hospital (Galveston, TX)

University Health System (San Antonio, TX)

University Hospital (San Antonio, TX)

University Medical Center of El Paso (El Paso, TX)

UT Health Northeast (Tyler, TX)

Utah

University of Utah Health Care (Salt Lake City, UT)

Virginia

UVA Health System (Charlottesville, VA)

UVA Culpeper Hospital (Culpeper, VA)

UVA Medical Center (Charlottesville, VA)

Virginia Commonwealth University Health System (Richmond, VA)

Children's Hospital of Richmond (Richmond, VA)

MCV Hospitals (Richmond, VA)

VCU Pauley Heart Center (Richmond, VA)

Washington

UW Medicine (Seattle, WA)

Harborview Medical Center (Seattle, WA)

Northwest Hospital & Medical Center (Seattle, WA)

UW Medical Center (Seattle, WA)

Valley Medical Center (Renton, WA)

West Virginia

WV United Health System (Morgantown, WV)

Berkeley Medical Center (Martinsburg, WV)

Camden Clark Medical Center (Parkersburg,
WV)

Chestnut Ridge Center (Morgantown, WV)

Jefferson Medical Center (Ranson, WV)

Ruby Memorial Hospital (Morgantown, WV)

United Hospital Center (Bridgeport, WV)

WVU Children's Hospital (Morgantown, WV)



Bylaws of America's Essential Hospitals

September 4, 2013

BYLAWS OF AMERICA'S ESSENTIAL HOSPITALS

ARTICLE I. NAME

The name of this corporation shall be America's Essential Hospitals ("the Association").

ARTICLE II. PURPOSE

The Association's purposes shall be as set forth in the Articles of Incorporation.

ARTICLE III. MEMBERS

3.1. Membership.

a. **Full members.** Public and non-profit acute care hospitals and multi-hospital systems with common missions and purposes, including patient populations or other significant characteristics and interests consistent with the purposes of the Association, shall be eligible to apply for Full membership in the Association, subject to the approval of the Board of Directors. Each Full Member shall have at least one vote on each matter brought before the membership, with the specific number of votes provided to each Full Member to be determined by the Board of Directors. For-profit hospitals shall not be eligible for membership of any class in the Association.

b. **Nonvoting Members.** The Board of Directors may approve nonvoting associate members from among health systems not considered for Full membership, which share common characteristics with the Association's Full Members. It may further approve nonvoting affiliate members from among individuals or organizations other than health systems wishing to support and participate in Association activities. Nonvoting members shall not have the right to vote on any matter.

c. **Board of Directors Approval.** The Board of Directors shall approve only those applicants for membership whose participation in the Association will, in the sole discretion of the Board of Directors, be consistent with and further the purposes and mission of the Association.

3.2. Powers.

The members shall have those rights as are set forth in these Bylaws, the Articles of Incorporation, and the District of Columbia Nonprofit Corporation Act of 2010 (the "Act").

3.3. Representatives.

At any meeting of members, each Full Member shall be represented by an individual designated by the Full Member to exercise voting rights on behalf of the Full Member (the

“Voting Delegate”). Each Full Member must designate one Voting Delegate for each vote provided to the Full Member. The Association will maintain a list of Voting Delegates. A Full Member must provide notice of a change in its Voting Delegate to the Secretary of the Association at least five (5) days in advance of a meeting of the membership or other vote of the membership.

3.4. Withdrawal and Termination.

Any member may, upon payment of any unpaid obligations to the Association, withdraw from membership at any time by giving at least thirty (30) days advance written notice to the President. The Board of Directors may, by a two-thirds (2/3) vote of the entire Board of Directors, terminate the membership of any member if it determines in its sole discretion that continued membership would be inimical to the best interests of the Association. Withdrawal or termination of a membership shall not relieve a member from any obligations incurred or commitments made prior to the withdrawal or termination.

ARTICLE IV. DUES

4.1. Dues.

The annual dues for each category of membership, and the method of collection for such dues, shall be determined by the Board of Directors.

4.2. Arrears.

Any member failing to pay its annual dues within thirty (30) days from the time they become due shall be so notified by the President or other appropriate official, and if payment is not made within the succeeding thirty (30) days the member may be reported to the Board of Directors as in arrears.

ARTICLE V. MEMBERS’ MEETINGS

5.1. Meetings of Members.

A meeting of the members shall be held at least once each year. Special meetings may be called by the Board of Directors, or by the petition of at least one-fourth (1/4) of the Full Members. Each regular and special meeting shall be held at a time and place set by the Board of Directors. Any meeting of the members need not be held at a geographic location if the meeting is instead held by means of the Internet or other electronic communications technology in a fashion pursuant to which the members have the opportunity to read or hear the proceedings substantially concurrently with their occurrence, vote on matters submitted to the members, pose questions, and make comments.

5.2. Quorum and Voting.

The presence of members with one-third (1/3) of the voting power shall constitute a quorum. Unless otherwise required by the Articles of Incorporation, these Bylaws, or the Act, the affirmative vote of a majority of the voting power present and voting at a meeting at which a quorum is present shall be the action of the membership.

5.3. Notice of Meeting.

Notice specifying the date, time and place, and in the case of a special meeting, the purposes of the meeting, shall be provided to all Full Members no fewer than ten (10) days prior to the meeting.

5.4. Action by Ballot.

Except as otherwise set forth in the Articles of Incorporation or these Bylaws, any action that may be taken at any regular or special meeting of members may be taken without a meeting if the Association delivers a ballot to every member entitled to vote on the matter. The ballot must set forth each proposed action; in the event of an election, provide an opportunity to vote for, or withhold a vote for, the slate of candidates nominated for election as a director or officer; and provide an opportunity to vote for or against each other proposed action. Ballots may be submitted electronically. Approval by ballot, other than the election of directors, is valid when the number of votes cast by ballot equals or exceeds the quorum required to be present at a meeting authorizing the action, and the number of approvals equals or exceeds the number of votes that would be required to approve the matter at a meeting at which the total number of votes cast was the same as the number of votes cast by ballot. Any solicitation for votes by ballot must state: (i) the number of responses needed to meet quorum requirements; (ii) the percentage of approvals necessary to approve each matter other than the election of directors or officers; and (iii) the date by which the ballot must be received in order to be counted.

5.5. Proxy Voting.

Voting by proxy is permitted.

ARTICLE VI. BOARD OF

DIRECTORS 6.1. Functions and Powers.

The business and affairs of the Association shall be managed by a Board of Directors. The Board shall number not less than fifteen (15), nor more than twenty (20), persons, including the officers of the Association. In addition, if UHC is a Full Member of the Association, the UHC president shall serve as a voting, *ex officio* member of the Board of Directors. The Chair, or in his or her absence, the Chair-elect, immediate Past-Chair, or President, in that order, shall preside at all meetings of the Board or the Executive Committee.

The Board shall establish and direct the policies of the Association; control its property and operations; be responsible for the expenditure of its funds; authorize Association positions on

major policy issues; approve budgetary matters; and exercise all of the powers of the Association except as otherwise provided by the Act, the Articles of Incorporation, or these Bylaws; provided, however, that the Executive Committee may exercise any such powers in the absence of Board action, as provided in this Article VI.

6.2. Qualification and Election of Directors.

Senior-level staff or trustees of an active Full Member shall be eligible for election to the Board of Directors. The members of the Board of Directors shall be elected annually by the Full Members from a slate of candidates developed by the Nominating Committee. The slate shall be approved upon the majority vote of the Full Members voting where a quorum is satisfied, either at a meeting of the members or by a vote by ballot, with each ballot setting forth the slate of candidates.

6.3. Terms of Directors.

Directors shall serve staggered terms of two (2) years, with approximately one-half of the total number of Directors to be elected each year. Except as otherwise set forth in these Bylaws, a Director may serve up to three (3) consecutive terms. Notwithstanding, the term of any Director may be extended for up to one additional year by majority vote of the Board of Directors.

6.4. Resignation and Removal of Directors

A Director may resign at any time by providing written notice to the Chair, and such resignation shall be effective when the notice is delivered, unless the notice specifies a later effective time. A Director may be removed by a majority vote of the Full Members present and voting at a meeting at which a quorum is present. Notice of such meeting must state that the purpose, or one of the purposes, of the meeting is removal of the Director.

6.5 Vacancy

If a vacancy occurs on the Board of Directors for any reason, the vacancy may be filled by a majority of the Directors remaining in office even if they constitute less than a quorum, and the Director shall serve until the expiration of the vacated term and until his or her successor is elected and qualified.

6.6. Meetings and Notice.

Regular meetings of the Board of Directors shall be held approximately three times a year, at times and places within or outside the District of Columbia, as the Board may determine from time to time. Special meetings of the Board may be called by the Chair, the President, or by written request of three members of the Board. Written notice of the date, time and place of regular meetings shall be given at least ten (10) days prior to the meeting, provided that at the beginning of each one-year period, the Association may provide a single notice of all regularly scheduled meetings for that year, or for a lesser period, without having to give notice of each regular meeting individually. Written notice of the date, time and place of special meetings must be provided at least two (2) days prior to the meeting.

6.7. Quorum.

One-half (50%) of the members of the Board of Directors shall constitute a quorum at any meeting of the Board. Any action by a majority of those Directors voting at a meeting at which a quorum is present shall constitute action of the Board, unless otherwise required by the Articles of Incorporation, these Bylaws, or the Act.

6.8. Meeting by Remote Communications.

Meetings of the Board of Directors (if it is determined by the Chair to be practical), of the Executive Committee, or of any other committee, may be conducted by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can simultaneously hear each other during the meeting; and participation in a meeting pursuant to this provision shall constitute presence in person at the meeting.

6.9. Action without Meeting.

Any action required or permitted to be taken by the Board of Directors may be taken without a meeting if each Director signs a consent describing the action to be taken and delivers it to the Association. Such action will be considered the act of the Board of Directors when one or more consents signed by all members of the Board of Directors are delivered to the Association.

6.10. Conflicts of Interest.

Any conflict or potential conflict of interest on the part of an officer or director shall be disclosed and addressed in accordance with the Conflict of Interest policy adopted by the Board of Directors.

ARTICLE VII. COMMITTEES

7.1. Executive Committee.

The Executive Committee shall have, and may exercise between meetings of the Board, the authority of the Board in the management of the Association, with regard to all matters not expressly reserved for consideration and action by the Board under these Bylaws or the Act. With regard to major policy matters (such as legislative action and issues of litigation) where time is of the essence and a meeting of the Board cannot be promptly convened, the Executive Committee may at its discretion approve an Association action or position.

The Executive Committee shall consist of the Chair, immediate past-Chair, Chair-elect, Secretary, and Treasurer. The Executive Committee shall report to the Board of Directors regarding all decisions made and actions taken by the Executive Committee..

The Chair of the Board shall serve as the Chair of the Executive Committee.

7.2. Nominating Committee.

The Chair, immediate past Chair and Chair-elect shall serve as the Nominating Committee with the Chair-elect serving as Chair of the Committee. The Nominating Committee shall meet annually for the purpose of developing a list of candidates for the election of the Board of Directors and officers and shall submit at least one name for each position to the Board for review and submission to the Full members. In the event that a vacancy exists in the office of Chair, immediate past Chair or Chair-elect, the remaining members of the Executive Committee shall appoint a member of the Board, who may not be a candidate for election, to serve on the Nominating Committee.

7.3. Finance Committee.

A Finance Committee shall be made up of members of the Board of Directors and shall be chaired by the Treasurer. The Finance Committee shall oversee the financial affairs of the Association; supervise the preparation of annual audited financial statements of the Association; and prepare an annual budget. In addition, the Finance Committee shall work in close consultation with the finance committee of the Essential Hospitals Institute (the “Institute”) in coordinating the activities of the two organizations.

7.4. Other Committees.

Committees consisting solely of members of the Board of Directors and having and exercising the authority of the Board, as delegated by the Board of Directors, may be created, and members of such committees appointed, by the Chair, subject to the approval of a majority of all Directors in office. Other committees not having and exercising the authority of the Board in the management of the Association may be designated, and members of such committees appointed, by the Chair.

ARTICLE VIII. OFFICERS

8.1. Number, Term and Election.

The officers of the Board shall consist of a Chair, a Chair-elect, the immediate past-Chair, a Secretary and a Treasurer. The Secretary and the Treasurer shall each serve for a maximum of two consecutive one-year terms and until his or her successor has been elected and qualified. The Chair-Elect shall serve in that office for a term of one year and until his or her successor has been elected and qualified, shall serve as Chair for the subsequent year, and shall serve on the Executive Committee as immediate past-Chair for the next subsequent year. The term of any officer may be extended for up to one additional year by majority vote of the Board of Directors. The term of each officer shall begin on July 1 of the year in which he or she is elected or, in the case of the Chair, succeeds to office.

The Chair-elect of the Board of Directors, Secretary, and Treasurer shall be elected each

year by the Full Members. His or her two-year term as a Director that would otherwise end during this period shall be extended until expiration of his or her term as immediate past-Chair. These officers shall be nominated by the Nominating Committee. Any other Board members may submit a nomination for himself/herself or another individual for the position of Chair-elect, Secretary or Treasurer, to the Nominating Committee. The Nominating Committee, in its sole discretion, shall determine the candidates for office that will be submitted to the Full Members.

8.2 Chair

The Chair shall preside at all meetings of the Board of Directors, shall be the principal officer of the Board of Directors and shall perform such other duties as may be assigned to him or her by the Board of Directors.

8.3. Treasurer.

The Treasurer shall be in general charge of the Association's funds. He or she shall supervise the establishment of proper accounting procedures for the handling of the Association's funds and shall be responsible for the proper custody of such funds. He or she shall chair the Finance Committee and shall report on the financial condition of the Association at all meetings of the Board, and at the end of each fiscal year he or she shall be responsible for supervising the preparation of an annual financial report, which shall reflect an audit by a certified public accountant.

8.4. Secretary.

The Secretary of the Association shall have custody of the Corporate Seal of the Association and shall be generally responsible for the Association's records and record-keeping. The Secretary shall prepare or supervise the preparation of the minutes of the meetings of the Board of Directors and the membership, and maintain and authenticate the records of the Association required to be kept pursuant to the Act.

8.5. Additional Officers.

In addition to the officers above-mentioned, other officers and agents, who need not be members of the Board of Directors, may from time to time be provided for by the Board of Directors, and each such officer or agent shall be appointed by the Board with title, powers and duties as prescribed by the Board.

8.6. Compensation.

Directors shall serve without compensation, but may receive reimbursement of out-of-pocket expenses incurred on Association business. Compensation of officers and agents, if any, shall be set by the Board of Directors.

8.7. Resignation, Removal and Vacancy.

An officer of the Board may resign at any time by delivering notice to the Association. Resignation shall be effective when the notice is delivered unless the notice specifies a later effective time. Any officer may be removed at any time by a resolution of the Board of Directors, with or without cause, but without prejudice to any contract rights of the person so removed. If a vacancy occurs among the Officers for any reason, the vacancy may be filled by a majority of the Board of Directors, and the Officer shall serve until the expiration of the vacated term and until his or her successor is elected and qualified. Notwithstanding, in the event that the Chair position is vacant, the Chair-Elect shall assume the position of Chair, and the Board of Directors shall fill the position of Chair-Elect.

ARTICLE IX. PRESIDENT AND CHIEF EXECUTIVE OFFICER

9.1 President and Chief Executive Officer

The President and Chief Executive Officer shall be appointed by and report to the Board. He or she shall serve as chief executive and key spokesperson for the Association, and shall have responsibility for the Association's implementation of strategic plan and vision; operations and staff; office administration; member services; member development; meetings, publications, and education programs; budgeting and finance; administration of any contract with the Institute; research activities and programs; agendas for all governance meetings, in consultation with the Association Chair; and coordination of Association policy and advocacy activities; implementation of the Association's legislative and regulatory policies and advocacy strategy; serve as a nationwide spokesperson for member health systems; and shall have such other powers and perform such other duties as may be prescribed from time to time by the Board.

The President and Chief Executive Officer shall provide coordination of the Association Board and Executive Committee with the board and staff of the Institute. He or she shall be authorized to serve as a director of the Institute, and in that capacity shall represent the interests of the Association. If the President and Chief Executive Officer serves as an Institute director, he or she shall keep the Association Board informed of the activities of the Institute.

ARTICLE X. INDEMNIFICATION AND INSURANCE

10.1. Indemnification.

To the fullest extent permitted by the Act, the Association shall indemnify and hold harmless each officer and director of the Association against any and all liabilities, costs and expenses (including attorneys' fees and expenses) reasonably incurred by him or her or on his or her behalf in connection with any civil action or proceeding to which he or she may be a party by reason of his or her being or having been an officer or director of the Association, or by reason of any action alleged to have been taken or omitted by him or her in such capacity, except where

the injury or damage was a result of: (i) the willful misconduct of such person; (ii) a crime, unless such person had reasonable cause to believe that the act was lawful; (iii) a transaction that resulted in an improper personal benefit of money, property or services to such person; or (iv) an act or omission that was not in good faith and was beyond the scope of authority of the Association pursuant to the Act, the Association's Articles of Incorporation or these Bylaws. Such indemnity shall be effective only in the event that the interested officer or director provides the Board of Directors of the Association, within a reasonable time after the institution of such action or proceeding, written notice thereof. Such indemnity shall not be deemed exclusive of any other rights to which those indemnified may be entitled under any Bylaw, agreement or otherwise. Such indemnity shall inure to the benefit of the heirs, executors or administrators of each officer and director.

10.2. Insurance.

The Association may purchase and maintain insurance on behalf of any director, officer, employee or agent of the Association against any liability asserted against or incurred by such person in such capacity or arising out of such status, including reasonable counsel's fees, whether or not the Association would have the power to indemnify that individual under the provisions of these Bylaws.

ARTICLE XI. FISCAL YEAR

The fiscal year of the Association shall be January 1 through December 31.

ARTICLE XII. AMENDMENTS

Amendments to these Bylaws must first be adopted by the Board of Directors. Following adoption by the Board of Directors, amendments must be submitted to the Full Members for approval. At least a majority of Full Members present and voting at a meeting, or by a ballot vote, where a quorum has been satisfied, must approve the amendments.

Secretary's Certificate

I, the undersigned Secretary of America's Essential Hospitals, a District of Columbia nonprofit corporation, hereby certify that:

The attached is a true copy of the Bylaws of the Association as revised by vote of the membership on September 4, 2013.

Signed and delivered on this 1st day of October, 2013

Johnese Spisso
(signature)

Johnese Spisso
(print name)



Bylaws of the Essential Hospitals Institute

September 4, 2013

BYLAWS OF THE ESSENTIAL HOSPITALS INSTITUTE

ARTICLE I. NAME

The name of this corporation shall be the Essential Hospitals Institute ("the Institute").

ARTICLE II. BOARD OF DIRECTORS

2.1. Board of Directors. The Board of Directors shall consist of sixteen (16) directors, including nine (9) Member Directors, five (5) Outside Directors, and two (2) *Ex Officio* Directors.

2.2. Member Directors. Only the senior executives or trustees of a Full Member of America's Essential Hospitals (the "Association") shall be eligible to serve as a Member Director. If a Member Director ceases to be eligible during his or her term as director, then that Board seat shall automatically be deemed vacant, and the remaining members of the Board of Directors may appoint a director to fill the vacancy for the remainder of the term.

2.3. Outside Directors. An Outside Director need not be affiliated with any member of the Association.

2.4. *Ex Officio* Directors.

2.4.1. The President and CEO of the Association shall serve, *ex officio*, as a voting director of the Institute.

2.4.2. Biannually, the President of UHC shall designate a senior UHC executive to serve, *ex officio*, as a voting director of the Institute.

2.4.3. There is no limit on the number of consecutive terms that an individual may serve as an *ex officio* director.

2.5. Election. The Board of Directors of the Association shall elect the Member Directors and Outside Directors (the Member and Outside Directors shall be collectively referred to as the "Elected Directors" herein).

2.6. Terms. Each Elected Director shall serve for a term of two (2) years and until his or her successor is elected and qualified. Each Elected Director may serve on the Board for a maximum of three (3) consecutive terms, subject to the provisions of section 6.1.3 below. Elected Directors' terms of office shall be staggered, with approximately one-half of the total number of Elected Directors to be elected each year. The term of each director shall begin on July 1 of the year in which he or she is elected or succeeds to office. Notwithstanding the foregoing, the term of any Director may be extended for up to one additional year by majority vote of the Board of Directors, and any Director who has been appointed Chair-elect shall continue to serve as a director for so long as he/she holds the Chair-elect, Chair, or immediate past Chair, pursuant to Section 5.1.3 of these Bylaws.

2.7. Resignation and Removal of Directors

A Director may resign at any time by providing written notice to the Chair, and such resignation shall be effective when the notice is delivered, unless the notice specifies a later effective time. An Elected Director may be removed upon the recommendation for removal by the Board of Directors of the Institute, and the approval of such recommendation for removal by a majority vote of the Board of Directors of the Association.

2.8. Vacancy

If a vacancy occurs on the Board of Directors for any reason, the Board of Directors shall recommend an individual to fill such vacancy, and such recommendation shall be approved by the majority vote of the Board of Directors of the Association. The Director shall serve until the expiration of the vacated term and until his or her successor is elected and qualified.

ARTICLE III. MEETINGS

3.1. Meetings and Notice. Regular meetings of the Board of Directors shall be held on such dates and at such times and places as the Board of Directors shall from time to time determine, for the transaction of such business as may lawfully come before each meeting; except that such meetings shall be held at least once each year. Special meetings of the Board of Directors shall be held whenever called by or upon request of the Chair or the Institute Director, or by written request of three directors. Written notice of the time and place of meetings shall be given at least two (2) days prior to the meeting, provided that at the beginning of each one-year period, the Institute may provide a single notice of all regularly scheduled meetings for that year, or for a lesser period, without having to give notice of each regular meeting individually. The purpose of any special meeting shall be stated in the notice of such meeting.

3.2. Quorum. One-half (50%) of the Board of Directors shall constitute a quorum for the transaction of business at all Board meetings.

3.3. Voting. An affirmative majority vote of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, unless otherwise required by the Articles of Incorporation, these Bylaws, or the District of Columbia Nonprofit Corporation Act of 2010 (the “Act”).

3.4. Meeting by Remote Communication. Meetings of the Board of Directors or any committee thereof, may be conducted by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can simultaneously hear each other; and participation in a meeting pursuant to this provision shall constitute presence in person at such meeting.

3.5. Action Without Meeting. Any action required or permitted to be taken at any meeting of the Board of Directors or of any committee thereof, may be taken without a meeting if a written consent, stating the action so taken, shall be signed by all of the directors or committee members, respectively, who are entitled to vote on the action and delivered to the Institute. Such action will be considered the act of the Board of Directors, or a committee thereof, when one or more consents signed by all members of the Board of Directors or committee, are delivered to the Institute.

director shall be disclosed and addressed in accordance with the Conflict of Interest policy adopted by the Board of Directors.

ARTICLE IV. COMMITTEES

4.1. Committees. Committees consisting solely of members of the Board of Directors, and having and exercising the authority of the Board, as delegated by the Board of Directors, may be created, and members of such committees appointed, by the Chair, subject to the approval of a majority of all directors in office. Other committees not having and exercising the authority of the Board in the management of the Institute may be designated, and members of such committees appointed, by the Chair, subject to the approval of the Board of Directors. The duties of any such committee shall be prescribed by the Chair upon its designation, and the committee shall limit its activities to the accomplishment of the tasks for which it is designated and shall have no power to act except as specifically conferred by action of the Board of Directors.

4.2. Nominating Committee. The Chair, immediate past Chair and Chair-elect shall serve as the Nominating Committee, with the Chair-elect serving as Chair of the Committee. The Nominating Committee shall meet annually for the purpose of developing a list of candidates for the election of the Board of Directors and officers and shall submit at least one name for each position for election by the Association Board of Directors.

4.3. Finance Committee. A Finance Committee shall be made up of members of the Board of Directors and shall be chaired by the Treasurer. The Finance Committee shall oversee the financial affairs of the Institute; supervise the preparation of annual audited financial statements of the Institute; and prepare an annual budget. In addition, the Finance Committee shall work in close consultation with the finance committee of the Association in coordinating the activities of the two organizations.

ARTICLE V. OFFICERS

5.1. Number, Term and Election.

- 5.1.1. The officers of the Board shall include the Chair, Chair-Elect, immediate past Chair, Secretary, and Treasurer. The Chair-Elect and Treasurer shall be elected by the Association Board of Directors on an annual basis, and each shall serve for a maximum of two consecutive one-year terms and until his or her successor in such office has been elected and qualified. The Chair-Elect shall simultaneously serve as Secretary during his or her term as Chair-Elect, shall serve as Chair for the subsequent year, and shall serve as immediate past Chair for the next subsequent year; and shall serve in each office until his or her successor assumes the position. Only an Elected Director shall be qualified to serve as an officer of the Board.
- 5.1.2. The term in office of each officer shall begin on July 1 of the year in which he or she is elected or succeeds to office.
- 5.1.3. A Chair-Elect is elected for three consecutive one-year terms as an officer: Chair-Elect & Secretary; Chair; and immediate past Chair. His or her two-year term as a Director that would otherwise end during this period shall be extended until

expiration of his or her term as immediate past-Chair.

5.2. Resignation, Removal and Vacancy. Any officer may resign at any time by giving written notice to the Chair of the Board. Unless otherwise specified in the notice, the resignation shall take effect upon receipt, without notice of acceptance. Any officer may be removed at any time by a resolution of the Board of Directors, with or without cause, but without prejudice to any contract rights of the person so removed. If a vacancy occurs among the Officers for any reason, the vacancy may be filled by a majority of the Board of Directors, and the Officer shall serve until the expiration of the vacated term and until his or her successor is elected and qualified. Notwithstanding, in the event that the Chair position is vacant, the Chair-Elect shall assume the position of Chair, and the Board of Directors shall fill the position of Chair-Elect.

5.3. Duties. The principal duties of the officers are as follows:

- 5.3.1. **Chair.** The Chair shall preside at all meetings of the Board of Directors, shall be the principal officer of the Board of Directors and shall perform such other duties as may be assigned to him or her by the Board of Directors. If the Chair is unable to preside at a meeting of the Board of Directors for any reason, the Chair-elect, immediate Past-Chair, or Institute Director, in that order, shall preside at all meetings of the Board in the Chair's absence.
- 5.3.2. **Secretary.** The Secretary shall have charge of the records and correspondence of the Institute under the direction of the Chair, and shall be custodian of the seal of the Institute, if any. The Secretary shall attend and take and keep or cause to be kept true minutes of all meetings of the Board of Directors, and shall maintain and authenticate the records of the Institute required to be kept pursuant to the Act. The Secretary shall discharge such other duties as shall be prescribed from time to time by the Chair or the Board of Directors.
- 5.3.3. **Treasurer.** The Treasurer shall keep or cause to be kept account of all moneys, credits and property of the Institute and shall be responsible for the proper custody of all funds. The Treasurer shall establish proper accounting procedures for the handling of the Institute's funds and shall keep proper books of account showing at all times the amount of the funds and other property belonging to the Institute. The Treasurer shall chair the Finance Committee and shall report on the accounts and financial condition of the Institute at all meetings of the Board of Directors, and at the end of each fiscal year shall prepare an annual financial report which shall reflect an audit of a certified public accountant.
- 5.3.4. **Additional Officers.** The Board of Directors may appoint such officers, in addition to those provided for in this Article V, as the Board may deem necessary. Each officer appointed shall have the authority and perform the duties prescribed by the Board of Directors. All appointive officers shall hold their respective offices or positions at the pleasure of the Board of Directors, and may be removed from office or discharged at any time with or without cause; provided that removal without cause shall not prejudice the contract rights, if any, of such officers. Appointment of such officers shall not of itself create any contract rights in such officers.

5.4. Compensation. Directors shall serve without compensation, but may receive reimbursement of out-of-pocket expenses incurred on business of the Institute. Compensation of officers and agents, if any, shall be fixed by the Board of Directors.

ARTICLE VI. INSTITUTE DIRECTOR

The Institute Director shall be appointed by the Board of Directors in consultation with the Association President and CEO. The Institute Director shall report to the Association President and CEO. The Institute Director shall serve the role of president of the Institute and exercise overall management and day to day supervision over the affairs of the Institute; shall discharge the duties of the Chair in the event of the Chair's absence or disability for any cause whatsoever; shall serve as a nonvoting, *ex officio* member of each committee of the Board; and shall have such other powers and perform such other duties as may be prescribed from time to time by the Board of Directors. The person serving as Institute Director shall not simultaneously serve as Secretary.

ARTICLE VII. INDEMNIFICATION OF DIRECTORS AND OFFICERS

7.1. Indemnification. To the fullest extent permitted by the Act, the Institute shall indemnify and hold harmless each officer and director of the Institute against any and all liabilities, costs and expenses (including attorneys' fees and expenses) reasonably incurred by him or her or on his or her behalf in connection with any civil action or proceeding to which he or she may be a party by reason of his or her being or having been an officer or director of the Institute, or by reason of any action alleged to have been taken or omitted by him or her in such capacity, except where the injury or damage was a result of: (i) the willful misconduct of such person; (ii) a crime, unless such person had reasonable cause to believe that the act was lawful; (iii) a transaction that resulted in an improper personal benefit of money, property or services to such person; or (iv) an act or omission that was not in good faith and was beyond the scope of authority of the Institute pursuant to the Act, the Institute's Articles of Incorporation or these Bylaws. Such indemnity shall be effective only in the event that the interested officer or director provides the Board of Directors of the Institute, within a reasonable time after the institution of such action or proceeding, written notice thereof. Such indemnity shall not be deemed exclusive of any other rights to which those indemnified may be entitled under any Bylaw, agreement or otherwise. Such indemnity shall inure to the benefit of the heirs, executors or administrators of each officer and director.

7.2. Insurance. The Institute may purchase and maintain insurance on behalf of any director, officer, employee or agent of the Institute against any liability to which he or she may be or become subject by reason of such status, including reasonable counsel's fees, whether or not the Institute would have the power to indemnify that individual under the provisions of these Bylaws.

ARTICLE VIII. GENERAL PROVISIONS

8.1. Fiscal Year. The fiscal year of the Institute shall be January 1 through December 31.

8.2. Exempt Activities. Notwithstanding any other provision of these Bylaws, no director, officer, employee or representative of the Institute shall take any action or carry on any activity

by or on behalf of the Institute which is not permitted to be taken or carried on by an organization exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, as now in effect or hereafter amended (the "Code"), or by an organization contributions to which are deductible under Sections 170(c)(2), 2055(a)(2) or 2522(a)(2) of the Code.

ARTICLE IX. AMENDMENTS

These Bylaws may be altered, amended or repealed, or new Bylaws may be adopted, by the affirmative vote of a majority of the Board of Directors present and voting at a meeting at which a quorum is present, subject to the approval of the Association Board of Directors.

CERTIFICATE

I, the undersigned Secretary of the Essential Hospitals Institute, a District of Columbia nonprofit corporation, hereby certify that:

The attached is a true copy of the Bylaws of the Institute as revised by vote of the Board September 4, 2013.

Signed and delivered on this 30th day of September, 2013

Caroline M. Jacobs
(signature)

Caroline M. Jacobs
(print name)



Statement of Investment Policy



Mission and Commitment Statement

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Since 1981, America's Essential Hospitals has initiated, advanced, and preserved programs and policies that help these hospitals ensure access to care. America's Essential Hospitals supports members with advocacy, policy development, research, and education.

Our members are vital to their communities, providing primary through trauma care, disaster response, health professionals training, research, public health programs, and other services. They innovate and adapt to lead the broader health care community toward more effective and efficient care.

Statement of Purpose

The purpose of this Investment Policy Statement (together with its Appendix, the "Statement") is to set forth the policies and procedures that shall guide the Investment, Audit & Compliance (IAC) committee and the Board of Directors (the "Board") of America's Essential Hospitals in supervising and monitoring the management of the organization's investable assets (the "Fund").

Roles and Responsibilities

If the Board elects to oversee investment matters directly, it shall undertake the roles and responsibilities prescribed for the Investment, Audit & Compliance committee herein. Otherwise, the IAC committee shall implement the management process and monitor the Fund in accordance with this Statement.

The IAC committee, acting pursuant to this Statement and to instructions from the Board, shall have direct responsibility for the oversight and management of the Fund and for the establishment of investment policies and procedures.

The IAC committee shall, as more fully described herein, manage the Fund via a set of asset allocation targets and ranges for the portfolio.

General Principles



America's Essential Hospitals shall diversify the investments of the Fund unless the Board and, if applicable, the IAC committee, after appropriate deliberation, reasonably determine that because of special circumstances the purposes of the Fund are better served without diversification.

The Fund shall be managed in accordance with high standards of fiduciary duty and in compliance with applicable laws and regulations.¹

Standards for return, asset allocation and diversification shall be determined from a strategic perspective and measured over successive market cycles.

This Statement shall be reviewed annually by the IAC committee and any recommendations for changes presented to the Board.

In fulfilling its responsibilities under this Statement, the committee shall, among other activities, recommend to the Board the hiring and dismissal of investment managers, fiscal agents and other advisors.

Reports on the Fund shall be provided at least three times per year to the IAC committee. The Financial Advisor shall be responsible to the committee for maintaining detailed records of all invested funds and for carrying out the investment policies and procedures established by the Board and the IAC Committee.

[1 Including but not limited to the version of the Uniform Prudent Management of Institutional Funds Act enacted in this state, if applicable.]



Goals and Objectives

Investment Objectives of the Fund:

The Fund (hereby referred to “collectively” as the operating and reserve funds) has a long-term investment horizon. The primary investment objectives of the Fund are to:

1. Maintain the real purchasing power of the Fund after inflation, costs and spending;
2. Provide a stable source of liquidity and financial support for the organization’s mission.

Investment Philosophy:

While acknowledging the importance of preserving capital, the Board also recognizes the necessity of accepting risk if the Fund is to be able to meet its long-term investment goals. It is the view of the Board that choices made with respect to asset allocation will be the major determinants of investment performance. The IAC committee shall seek to ensure that the risks taken are appropriate and commensurate with the Fund’s goals.

Investment Operating Guidelines and Procedures

The Fund shall be managed in accordance with the Operating Guidelines described in this section. The Fund’s target asset allocation and range for each asset class or investment strategy, together with the applicable guidelines and restrictions are outlined in Appendix A. Taken together, these guidelines constitute a framework to assist America’s Essential Hospitals and its investment managers in achieving the Fund’s investment objectives at a level of risk consistent with the parameters set forth in this Statement.

Once the Operating Guidelines have been approved by the Board, the IAC committee shall have the authority to manage the Fund within the Operating Guidelines without further authorization from the Board.



Investments in mutual funds or commingled funds shall be reviewed and approved by the IAC committee on a case-by-case basis and, if approved, may vary from this Statement. For each such mutual or commingled fund, the prospectus, offering memorandum or Declaration of Trust documents of the respective fund will govern the investment policies of the fund investments. While the IAC committee understands that such funds have their own stated guidelines which cannot be changed for individual investors, those guidelines should be similar in principle and spirit to the guidelines stated herein. To the extent that a mutual or commingled fund departs from any or all of such guidelines, the IAC committee shall make itself aware of the possible consequences and be confident that the investment manager thoroughly understands the risks being taken, has demonstrated expertise in such investment strategies and has guidelines in place for monitoring their risk-adjusted performance.

The Fund shall be diversified both by asset class and within asset classes. Within each asset class, investments shall be diversified further among economic sector, industry, quality and size. The purpose of this diversification is to provide a reasonable assurance that no single security or class of securities will have a disproportionate impact - positive or negative - on the overall performance of the Fund.

Investment Policy

Asset allocation: The IAC committee shall, consistent with the above sections, invest the Fund using an asset allocation, as set forth in Appendix A, that is designed to meet the Fund's long-term goals. The allocation will be based on the objectives of the Fund as set forth above.

Targets and ranges: The asset allocation shall be implemented using a policy portfolio as set forth in Appendix A, with target allocations and ranges for each investment strategy. Due to the need for diversification and the longer funding periods for certain investment strategies, the IAC committee recognizes that an extended period of time may be required to fully implement the asset allocation plan.



Rebalancing: The purpose of rebalancing is to maintain the Fund's policy asset allocation within the targeted ranges, thereby ensuring that the Fund does not incur additional risks as a result of having deviated from the policy portfolio. It is expected that market value fluctuations will cause deviations from the target allocations to occur. However, if any target allocation moves outside of the target range the portfolio will be rebalanced. Other events that may trigger a rebalance include large deposits or withdrawals and significant market movements. Regardless of activity the portfolio will be reviewed on a quarterly basis at a minimum to assure the balance is adequately maintained. In order to minimize transaction costs, the Designated Investment Advisor will evaluate the benefit of rebalancing relative to the transaction cost.

Illiquid investments: Because of their long-term nature, investments in and commitments to illiquid investment strategies, including but not limited to private capital, private equity real estate, natural resources, distressed debt and other similar private investments, shall be analyzed and discussed by the IAC committee separately.

Standard of conduct: In managing and investing the Fund, the IAC committee shall:

- act in good faith and with the care an ordinarily prudent person in a like position would exercise under similar circumstances;
- make a reasonable effort to verify facts relevant to the management and investment of the Fund;
- consider the following factors, if relevant:
 - (a) general economic conditions;
 - (b) the possible effect of inflation or deflation;
 - (c) the expected tax consequences, if any, of investment decisions or strategies;
 - (d) the role that each investment or course of action plays within the overall investment portfolio of the Fund;



(e) the expected total return from income and the appreciation of investments;

(f) other resources of America's Essential Hospitals;

(g) the needs of America's Essential Hospitals and the Fund to make distributions and to preserve capital;

- make management and investment decisions about an individual asset not in isolation, but rather in the context of the Fund's portfolio of investments as a whole and as a part of the organization's overall investment strategy, including the risk and return parameters set forth in this Statement.

Delegation: Subject to any specific limitation set forth in a gift instrument, the IAC committee may delegate to an external agent the management and investment of all or part of the Fund to the extent that America's Essential Hospitals could prudently delegate under the circumstances. The IAC committee shall act in good faith, with the care that an ordinarily prudent person in a like position would exercise under similar circumstances in: (1) selecting an agent; (2) establishing the scope and terms of the delegation, consistent with the purposes of America's Essential Hospitals and the Fund; and (3) periodically reviewing the agent's actions in order to monitor the agent's performance and compliance with the scope and terms of the delegation.

In this regard, the IAC committee shall engage qualified external professional investment managers that have demonstrated competence in their respective investment strategies. These managers shall have full discretion and authority for determining investment strategy, security selection and timing of purchases and sales of assets subject to the guidelines specific to their allocation.

Designated Investment Advisor: Will be responsible for implementing the investment strategy outlined in this policy statement by selecting investments and external managers that meet the investment criteria within this policy statement. The Designated Investment Advisor will be charged with



recommending investments, transacting approved purchases and sales of investments, and timely reporting of investment performance to America's Essential Hospitals. The Designated Investment Advisor is also required to perform all normal due diligence in selecting external investment managers, including a review of their ability to operate within the investment guidelines and restrictions outlined in this policy. The Designated Investment Advisor is responsible for selecting other appropriate parties as needed to implement this policy, including attorneys, custodians, and broker/dealers.

Investment Manager: Investment managers will be any party the Designated Investment Advisor selects to invest funds on behalf of America's Essential Hospitals. For purposes of this policy, Investment Managers include Mutual Fund Managers, Exchange Traded Fund Managers, Separate Account Managers, Money Market Fund Managers, and any other party that the Investment Manager contracts to invest funds on behalf of the association. The Investment Advisor is responsible for assuring that any Investment Manager selected is investing funds in a manner consistent with the eligible investments and restrictions outlined in this policy.

Investment manager reporting and evaluation: The Designated Investment Advisor responsible for the investment of the Fund's assets shall report on their performance at least three times per year. Reports shall include, at a minimum, (1) comparative returns for the Fund assets under management against a portfolio benchmark and the performance of each underlying fund or separately managed account in the portfolio against a style and size specific benchmark, (2) a complete accounting of all transactions involving the Fund during the reporting period, and (3) the current portfolio allocation compared to the target asset allocation.

When possible, the IAC committee shall monitor and compare the Fund's performance relative to its (1) absolute return objectives for the Fund; (2) the respective benchmarks for each asset class or strategy in which the Fund is invested, as set forth in the asset allocations in Appendix A, and (3) a representative group of peer investment managers.



Appendix A: Operating Guidelines

Definitions of Allowable Investments:

Equity Securities: The purpose of equity investments, both domestic and international, in the Fund is to provide capital appreciation, growth of income, and current income. This asset class carries the assumption of greater market volatility and increased risk of loss, but also provides a traditional approach to meeting portfolio total return goals. This component includes domestic and international common stocks, American Depository Receipts (ADRs), preferred stocks, and convertible stocks traded on the world's stock exchanges or over-the counter markets.

Public equity securities shall be restricted to high quality, readily marketable securities of corporations that are traded on the major stock exchanges, including NASDAQ, and have the potential for meeting return targets. Equity holdings must generally represent companies meeting a minimum market capitalization requirement of respective asset class profiles with reasonable market liquidity where customary. Decisions as to individual security selection, number of industries and holdings, current income levels and turnover are left to manager discretion, subject to the standards of fiduciary prudence.

Within the above guidelines and restrictions, the Fund's investment managers shall have complete discretion over the selection, purchase and sale of equity securities.

Fixed Income Securities: Domestic and international fixed income investments are intended to provide diversification and a dependable source of current income. Fixed income investments should reduce the overall volatility of the Fund's assets and provide a deflation or inflation hedge, where appropriate.

The fixed income asset class includes the fixed income markets of the U.S. and the world's other developed economies. It includes, but is not limited to, U.S. Treasury and government agency bonds, non-U.S. dollar denominated securities, public and private corporate debt, mortgages and asset-backed securities, and non-investment grade debt. Also included are money market instruments such as commercial paper, certificates of deposit, time deposits,



bankers' acceptances, repurchase agreements, and U.S. Treasury and agency obligations. The investment managers shall take into account credit quality, sector, duration, and issuer concentrations in selecting an appropriate mix of fixed income securities. Investments in fixed income securities shall be managed actively to pursue opportunities presented by changes in interest rates, credit ratings, and maturity premiums.

Within the above guidelines and restrictions, the Fund's investment managers shall have complete discretion over the selection, purchase and sale of fixed income securities.

For the purposes of this document Short Term Fixed income is defined as fixed income with a maturity of 5 years or shorter. Intermediate Term Fixed income is defined as fixed income with a maturity between 5 and 10 years.

Cash and Equivalents: The Fund's investment managers may invest in the highest quality commercial paper, repurchase agreements, U.S. Treasury Bills, certificates of deposit, and money market funds to provide income, liquidity for expense payments, and preservation of the Fund's principal value. Investments in the obligations of a single issuer shall not at time of investment exceed 5 percent of the Fund's total market value, with the exception of the U.S. Government and its agencies.

Since the IAC committee does not consider short-term cash equivalent securities to be appropriate investment vehicles for long-term portfolios, uninvested cash reserves shall be kept to a minimum except where needed to comply with the Fund's liquidity parameters. However, such vehicles are considered appropriate (i) as a depository for income distributions from longer-term investments, (ii) as needed for temporary placement of funds directed for future investment to longer-term investment strategies and (iii) for contributions to the current fund or for current operating cash.

Within the above guidelines and restrictions, the investment managers shall have complete discretion over the selection, purchase and sale of cash equivalent securities.



Investment Restrictions: The IAC committee may waive or modify any of the restrictions in these guidelines in appropriate circumstances. Any such waiver or modification shall be made only after a thorough review of the investment manager and investment strategy involved. An addendum supporting such waiver or modification shall be maintained as a permanent record of the IAC. All such waivers and modifications shall be reported to the Board at the meeting immediately following the granting of the waiver or modification.

Adherence to the restrictions in these guidelines shall be measured as of the time of initial investment. It is recognized that subsequent market action may result in the investment or strategy ceasing to adhere to these restrictions, through no fault of America's Essential Hospitals' staff or the respective outside manager. In such a situation, the organization and the manager shall make reasonable attempts to bring the investment or strategy back within adherence to these restrictions, bearing in mind the long-term interests of the organization and the Fund and the desirability of avoiding harmful forced sales of assets.

Diversification: (1) No more than 5% of the portfolio combined may be in the securities of any one issuer with the exception of obligations of the US Government and its agencies, and federally insured instruments. (2) No more than 20% of the portfolio combined may be in the securities of a particular industry.

Investment Strategies and Guidelines

Operating Fund

Purpose: To provide supplemental cash and liquidity needs for America's Essential Hospitals. The primary goal is to ensure working capital is invested as fully as possible in high quality, liquid fixed income securities to maximize investment income.

Investment Objectives: (1) Preservation of Capital and (2) Preservation of purchasing power.



Cash Flow Expectations: This portfolio provides a short term funding reserve to cover expenses related to special projects/initiatives that are not covered by the annual budget, or to replenish the checking account. As such, there are no known cash flow expectations; however, funds may be needed periodically in order to meet these needs. Any change in the association's need for cash flows from this account should be addressed through a change in this policy statement.

Target Allocations

	<u>Minimum</u>	<u>Target</u>	<u>Maximum</u>
Cash Equivalents	0 %	5%	10 %
Short Term Taxable Fixed Income	52 %	65 %	78 %
Intermediate Taxable Fixed Income	24%	30 %	36%

The Operating Fund will target a weighted average maturity of 3 years or less and a weighted average credit quality of no lower than AA.

Benchmarking: The portfolio will be compared to a benchmark comprised of Barclays Capital Aggregate Bond Index, Barclays Capital Gov. 1-3 Year Bond Index, and the Merrill Lynch Three Month US Treasury Bill Index. Weights will be applied to each index based on the target allocation to each broad asset class.

Long Term Reserve Fund

Purpose: To improve investment returns on the funds for future expenditures and to maintain the financial stability of America's Essential Hospitals. This can include fixed income securities and equities.

Investment Objectives: (1) Capital Appreciation and (2) Preservation of purchasing power.

Cash Flow Expectations: This portfolio is not expected to be a direct source of cash flow for AEH.



Target Allocations

	<u>Minimum</u>	<u>Target</u>	<u>Maximum</u>
Cash Equivalents	0 %	1 %	2 %
US Equities	29%	36%	43%
International Equities	15 %	19%	23 %
Fixed Income	36%	45%	54%

The fixed income asset class will target a weighted average maturity of 8 years or less and a weighted average credit quality of no lower than AA.

The domestic and international equity assets classes will reflect an allocation to all nine style boxes based on market capitalization (Large, Mid, Small) and style (Value, Blend, Growth.) The allocation to international equity will also include exposure to both developed and emerging markets.

Benchmarking: The portfolio will be compared to a benchmark comprised of the Russell 3000 Index, FTSE All World Ex-U.S. Index, Barclays Capital Aggregate Bond Index, Barclays Capital Gov. 1-5 Year Bond Index, and the Merrill Lynch Three Month US Treasury Bill Index. Weights will be applied to each index based on the target allocation to each broad asset class.



America's Essential Hospitals

RESERVE POLICY

The purpose of this Policy is to provide guidelines for maintaining adequate reserves.

DEFINITION OF RESERVES

Reserves are defined as the accumulated net surpluses of America's Essential Hospitals. The unrestricted net assets as reported on the Statement of Financial Position. The primary purpose of the reserve is to ensure that the organization has adequate funds available in the event of an unanticipated catastrophic event or business situation that reduces reserves and threatens the financial viability of the organization. A secondary purpose of the reserve is to support special projects in the event a single or multiple strategic initiatives surface during the course of the year, a Board member may make a motion to the full Board of Directors to fund such an initiative. An initiative is defined as an opportunity for the Association to invest in an action that will benefit the membership.

FUNDING REQUIREMENTS

America's Essential Hospitals shall have a goal of maintaining at least forty percent (40%) of annual budgeted expenses in its reserves. In the event the goal of 40% of annual operating expenses is not achieved, this occurrence would trigger a process through which the Finance Committee would convene to recommend necessary and sufficient corrective actions to pursue a recovery plan by (1) using the next year's budget surplus sufficient to rebuild the reserves' floor to a minimum of 40% of annually budgeted expenses, or (2) using a two-year budget cycle to rebuild the reserves' floor to a minimum of 40% of annually budgeted expenses. In either case, the recommendations will be presented to the Board of Directors during the budget approval process.

Footnote:

Because the principal audience for America's Essential Hospitals and Essential Hospitals Institute research and education activities is the America's Essential Hospitals' membership, America's Essential Hospitals has and will continue to financially support Essential Hospitals Institute. Therefore, this Reserve Policy applies only to America's Essential Hospitals.