AMERICA'S ESSENTIAL HOSPITALS

Board of Directors Meeting

June 24, 2014
The Westin Riverwalk | San Antonio

essentialhospitals.org

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AMERICA'S ESSENTIAL HOSPITALS

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AMERICA'S ESSENTIAL HOSPITALS

Agenda
Board of Directors Meeting
June 24, 2014
11 am – 5 pm

11 – 11:05 am	Call to Order and Disclosure of Conflicts of Interest (Mr. Traylor)	
11:05 – 11:10 am	Welcome New Board Members (Mr. Traylor)	
11:10 – 11:15 am	Approve Consent Agenda (Mr. Traylor) • March 31 Minutes • New members	ACTION
11:15 – 11:30 am	President and CEO Report (Dr. Siegel)	
11:30 – Noon	Employee Climate Assessment (Dr. Siegel)	
Noon – 12:30	Lunch	
12:30 – 12:45 pm	Treasurer's Report (Mr. Lopez)	ACTION
12:45 – 1 pm	Education Committee Report (Mr. Belzer)	
1 – 1:30 pm	Membership Committee Report: New Dues Structure (Mr. Lopez)	ACTION
1:30 – 1:45 pm	Policy Advisory Committee Report (Dr. Walker)	ACTION
1:45 – 3 pm	Policy/Advocacy Update (Dr. Feldpush)	
3 – 3:15 pm	Break	
3:15 – 3:45 pm	Update on NQF Risk Adjustment (Dr. Engler)	
3:45 – 4:15 pm	Investment Policy (Ms. Gold & Raffa Wealth Management)	ACTION
4:15 – 4:45 pm	Executive Session	
4:45 – 5 pm	Board Photo	
5 pm	Adjourn	

America's Essential Hospitals Board of Directors
2013–2014

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

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

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

TREASURER
David S. Lopez
President and CEO
Harris Health System

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

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

Reginald W. Coopwood, MD (2012–2014)
President and CEO
Regional One Health

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

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

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

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

Wright L. Lassiter, III (2014–2015)
CEO
Alameda Health System

Santiago Muñoz, III (2013–2015)
Chief Strategy Officer
UCLA Health System

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

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

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

EX OFFICIO
Irene M. Thompson
President and CEO
UHC

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2014–2015

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Grady Health System

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President and CEO
New York City Health and Hospitals Corporation

Sheldon M. Retchin, MD, MSPH (2014–2016)
CEO, VCU Health System
Virginia Commonwealth University Health System

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

Roxane A. Townsend, MD (2014–2016)
Vice Chancellor for Clinical Programs and CEO, UAMS Medical Center
University of Arkansas for Medical Sciences

EX-OFFICIO
Irene M. Thompson
President and CEO
UHC

AMERICA'S ESSENTIAL HOSPITALS

2014–2015 Association Board Meeting Dates

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

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

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

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

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

Board Members Present (13):	Board Members Absent (3):	Staff Present (13):
• 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)	• Timothy Goldfarb • George Hernandez • Steven Gabbe	• 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

Agenda Items	**Minutes**
Call to Order and Disclose Conflicts of Interest (Traylor)	• Call to order at 11:19 am • Request for conflicts of interest; none disclosed
Approve Consent Agenda (Traylor)	• Approve December 2013 meeting minutes • Approve October 2013 meeting minutes • Approve new members o Bon Secours Baltimore Health System, Baltimore o Erlanger Health System, Chattanooga, Tennessee o Liberty Health/Jersey City Medical Center, Jersey City, New Jersey o Oklahoma State University Medical Center, Tulsa, Oklahoma o United Medical Center, Washington, DC *Traylor requested a motion to approve the consent agenda. There was a motion, a second, and unanimous approval of the consent agenda.*
President and CEO's Report (Siegel)	• 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 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. • 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)	• 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: o Proposed officers: Anna Roth, RN, MS, MPH, chair-elect/secretary; Leon Haley, MD, MHSA, treasurer o Proposed new directors: Delvecchio Finley, MPP; Erica Murray, MPA

	○ Proposed re-elected directors: Susan Moffatt-Bruce, MD, PhD; Christine Neuhoff, JD *Traylor requested a motion to approve the Institute Board Nominations. There was a motion, a second, and unanimous approval of the Institute board candidates.*
Nominating Committee Report (Walker)	• 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. ○ 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. *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.*
Membership Committee Report (Lopez and Staff)	• 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. • 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	• Section 1115 Delivery System Reform Incentive Payment (DSRIP) waivers are

Committee Report (Belzer)	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)	• 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)	• 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 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). • 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. *(This later passed in the Senate).* This legislation

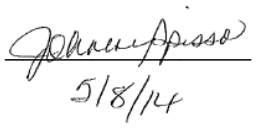
	contained an additional one-year delay of the Medicaid DSH cuts, pushing them back to FY 2017. . This legislation also included our language for a report on DSH and required the Medicaid and CHIP Payment and Access Commission (MACPAC) to report annually on the state of Medicaid DSH, which likely will 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 o train the next generation of clinicians and allied health professionals; o provide comprehensive coordinated care; o provide specialized services, such as trauma, burn, and psychiatric care; and o 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. . • 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)	• 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. • 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)	• 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. *Lopez requested a motion to approve the 2014 revised budget. There was a motion, a second, and unanimous approval of the 2014 revised budget.* • 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 Association Website (Graziano)	• The association launched a new website in early February 2014 after more than a year of research and development. Much of the work occurred concurrently with the association's rebranding process. • 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:



Johnese M. Spisso, RN, MPA
Secretary

AMERICA'S ESSENTIAL HOSPITALS

DATE June 16, 2014
TO Board of Directors
FROM Kristine Metter, Vice President of Member Services
RE New Member Applications MEMORANDUM

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

- Care New England Health System, Providence, Rhode Island
- East Alabama Medical Center, Opelika, Alabama
- University of Chicago Medical Center, Chicago
- University of Mississippi Medical Center, Jackson, Mississippi

Care New England Health System
Dennis Keefe, President and CEO

Care New England Health System operates four hospitals: Kent Hospital, a general acute care facility with about 360 beds; the 290-bed Memorial Hospital of Rhode Island; psychiatric facility Butler Hospital; and Women & Infants Hospital of Rhode Island, which specializes in obstetrics, gynecology, and newborn pediatrics. Combined, the system has more than 640 licensed beds. Care New England, formed in 1996 by its member hospitals, also operates a home health agency and outpatient care facilities.

Care New England Health System

Beds	723
Employees	4,418
Discharges (Medicare)	35.65%
Discharges (Medicaid)	33.34%
Outpatient visits	749,412
Total admissions	40,118
Births	9,809

Source: American Hospital Association (AHA) 2012 utilization statistics

East Alabama Medical Center
Terry Andrus
President and CEO

East Alabama Medical Center (EAMC) is a general medical and surgical hospital in northeast Alabama that serves Lee County and five surrounding counties. EAMC opened as an 81-bed hospital in 1952 and was called Lee County Hospital until 1982, when it became East Alabama Medical Center. The hospital is owned by the East Alabama Healthcare Authority, which has nine board members from throughout Lee County. Among the hospital's specialties are cardiology (including open-heart surgery), comprehensive cancer care, a sleep disorders center, orthopaedics, a da Vinci robotic surgery system, several radiology modalities (including a 3T MRI), renal/dialysis, and endoscopy.

East Alabama Medical Center

Beds	675
Employees	3,944
Discharges (Medicare)	24.78%
Discharges (Medicaid)	40.59%
Outpatient visits	226,224
Total admissions	28,489
Births	2,389

Source: AHA 2012 utilization statistics

University of Chicago Medical Center
Sharon O'Keefe, MSN, President

The University of Chicago Medicine, an academic medical center based in Hyde Park on the campus of the University of Chicago, is a not-for-profit corporation which includes:

- The Center for Care and Discovery, a state-of-the-art hospital with a focus on cancer, digestive diseases, neurosciences, advanced surgery and high-tech medical imaging
- Bernard A. Mitchell Hospital, dedicated to emergency medicine, maternity care, burn care, and transplant care
- Comer Children's Hospital, devoted to pediatric care
- Duchossois Center for Advanced Medicine (DCAM), a state-of-the-art ambulatory-care facility with the full spectrum of preventive, diagnostic, and treatment services
- University of Chicago Pritzker School of Medicine, one of the nation's premier medical schools

Their patient care system also includes physician offices in several Chicago locations, the suburbs, and northwestern Indiana and affiliations with several hospitals including LaRabida Children's Hospital (staffed by University of Chicago pediatricians), Mercy Hospital, Weiss Memorial Hospital and others.

University of Chicago Medical Center

Beds	568
Employees	7,114
Discharges (Medicare)	30.77%
Discharges (Medicaid)	28.43%
Outpatient visits	649,194
Total admissions	24,218
Births	1,464

Source: AHA 2012 utilization statistics

University of Mississippi Medical Center
James Keeton, MD, Vice Chancellor for Health Affairs

The University of Mississippi Medical Center (UMMC), in Jackson, is the state's only academic health science center. UMMC includes six health science schools: medicine, nursing, dentistry, health related professions, graduate studies, and pharmacy. Enrollment in all programs is more than 2,800 students. Four specialized hospitals on the Jackson campus include the only children's hospital in Mississippi, a women and infants' hospital, and a critical care hospital. UMMC offers the only level I trauma center, the only level IV neonatal intensive care nursery, and the only organ transplant programs in the state, in addition to many other referral services.

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Source: AHA 2012 utilization statistics

AMERICA'S ESSENTIAL HOSPITALS

DATE June 16, 2014
TO Board of Directors
FROM Rhonda Gold, Chief Financial Officer
RE Treasurer's Report

MEMORANDUM

This memorandum summarizes the 2013 audited financial statements and a 2014 financial projection compared with budget. The association's finance committee has reviewed and accepted the attached materials.

The following action items are requested from the board:

- accept America's Essential Hospitals 2013 audited financial statements as recommended by the investment, audit, and compliance and finance committees
- accept the 2014 budget update

2013 Audit

The investment, audit and compliance and finance committees both reviewed and accepted the attached 2013 audited financial reports. America's Essential Hospitals ended 2013 with total assets of $11.4 million, including $10 million in cash and investments; and $4.7 million in liabilities, mostly due to deferred revenue for 2014 membership dues invoiced and paid in 2013. The significant increase in cash is because the Essential Hospitals Institute reimbursed the association for intercompany transactions (totaling $3.2 million). After accounting for a $700,000 contribution to the Institute to support programmatic work and general and administrative costs, the association's unrestricted net assets totaled $6.5 million (in addition to a $250,000, board-designated operating reserve for to fund the organization's future office relocation).

As reflected on the Statements of Activities and Changes in Net Assets, the association ended the year with $8.8 million in revenue (including contributed legal services), which was offset by $6.98 million in expenses, leaving a $1.48 million change in unrestricted net assets ("operating surplus").

2014 Financial Update

The financial projection for the year is reflected in column 3 of Attachment I. We are pleased to report that projected revenue of $8.89 million is $185,000 more than budget because of new membership dues revenue; and projected expenses of $7.82 million are $8,100 better than budget because of lower projected building operating expenses. The changes in the policy, member services, and conferences budget lines reflect a reclassification of committee meetings from conferences to programs; there is no projected change in budgeted expenses at this time. The projected change in net assets (operating surplus) of $970,000 is $193,000 better than budget.

We will review these materials with you at the June board meeting, but should you have any questions before then, please contact Rhonda at 202-585-0109 or rgold@essentialhospitals.org.

Attachments:
2013 Audited Financial Statements
2014 Financial Projection compared to Budget (Attachment I)

FINANCIAL STATEMENTS

AMERICA'S ESSENTIAL HOSPITALS

FOR THE YEARS ENDED
DECEMBER 31, 2013 AND 2012

AMERICA'S ESSENTIAL HOSPITALS

CONTENTS

GELMAN, ROSENBERG
& FREEDMAN
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

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

We have audited the accompanying financial statements of America's Essential Hospitals, which comprise the statements of financial position as of December 31, 2013 and 2012, and the related statements of activities and changes in net assets, functional expenses and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

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MEMBER OF CPAMERICA INTERNATIONAL, AN AFFILIATE OF HORWATH INTERNATIONAL
MEMBER OF THE AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS' PRIVATE COMPANIES PRACTICE SECTION

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of America's Essential Hospitals as of December 31, 2013 and 2012, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

April 8, 2014

AMERICA'S ESSENTIAL HOSPITALS

STATEMENTS OF FINANCIAL POSITION
AS OF DECEMBER 31, 2013 AND 2012

ASSETS

	2013	2012
CURRENT ASSETS		
Cash and cash equivalents	$ 4,852,739	$ 1,078,675
Investments (Notes 2 and 11)	5,203,984	4,808,522
Accounts receivable	64,982	893,625
Due from Essential Hospitals Institute (Note 4)	55,007	1,388,241
Prepaid expenses	107,953	91,719
Total current assets	10,284,665	8,260,782
FURNITURE, EQUIPMENT AND LEASEHOLD IMPROVEMENTS		
Furniture and equipment	984,668	691,058
Computer equipment	24,154	17,752
Leasehold improvements	324,089	324,089
	1,332,911	1,032,899
Less: Accumulated depreciation and amortization	(1,041,510)	(894,256)
Net furniture, equipment and leasehold improvements	291,401	138,643
OTHER ASSETS		
Assets held for deferred executive compensation plan (Notes 5 and 11)	866,248	656,307
Deposits	20,503	20,503
Total other assets	886,751	676,810
TOTAL ASSETS	$ 11,462,817	$ 9,076,235

See accompanying notes to financial statements.

LIABILITIES AND NET ASSETS

	2013	2012
CURRENT LIABILITIES		
Accounts payable	$ 403,809	$ 561,546
Accrued expenses (Note 5)	671,119	366,135
Deferred revenue:		
Membership dues	2,520,800	1,984,575
Other	50,330	4,180
Deferred rent liability, current portion (Note 6)	43,626	36,211
Post-retirement medical plan annuity, current portion (Notes 3 and 11)	3,447	3,309
Total current liabilities	3,693,131	2,955,956
LONG-TERM LIABILITIES		
Deferred executive compensation plan liability (Note 5)	866,248	656,307
Deferred rent liability, net of current portion (Note 6)	51,195	94,821
Post-retirement medical plan annuity, net of current portion (Notes 3 and 11)	92,890	95,102
Total long-term liabilities	1,010,333	846,230
Total liabilities	4,703,464	3,802,186
NET ASSETS		
Unrestricted	6,509,353	5,174,049
Designated operating reserve (Note 7)	250,000	100,000
Total net assets	6,759,353	5,274,049
TOTAL LIABILITIES AND NET ASSETS	$ 11,462,817	$ 9,076,235

See accompanying notes to financial statements.

EXHIBIT B

AMERICA'S ESSENTIAL HOSPITALS

STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS
FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012

	Unrestricted	
	2013	2012
REVENUE AND SUPPORT		
Dues	$ 7,458,783	$ 6,956,250
Sponsorship income	454,495	488,490
Conference and tuition income	112,235	156,848
Investment income (Note 2)	395,462	309,935
Government Relation Academy	44,000	-
Royalty income	5,402	4,545
Miscellaneous	-	8,155
Subtotal before contributed services and materials	8,470,377	7,924,223
Contributed services and materials (Note 9)	329,273	175,065
Total revenue and support	8,799,650	8,099,288
EXPENSES		
Program Services:		
Member Services	2,811,957	2,239,823
Lobbying and Advocacy	1,379,405	1,153,546
Policy	1,052,453	1,157,632
Total program services	5,243,815	4,551,001
General and Administrative	1,041,258	1,170,462
Total program and general and administrative before allocation of contributed legal services	6,285,073	5,721,463
Contributed legal services (Note 9)	329,273	175,065
Total expenses including contributed legal services	6,614,346	5,896,528
Changes in net assets before other item	2,185,304	2,202,760
OTHER ITEM		
Contribution to Essential Hospitals Institute (Note 4)	700,000	700,000
Changes in unrestricted net assets	1,485,304	1,502,760
Unrestricted net assets at beginning of year	5,274,049	3,771,289
UNRESTRICTED NET ASSETS AT END OF YEAR	$ 6,759,353	$ 5,274,049

See accompanying notes to financial statements.

EXHIBIT C

AMERICA'S ESSENTIAL HOSPITALS

STATEMENT OF FUNCTIONAL EXPENSES
FOR THE YEAR ENDED DECEMBER 31, 2013

	Program Services					
	Member Services	Lobbying and Advocacy	Policy	Total Program Services	General and Administrative	Total Expenses
Salaries, taxes and benefits (Notes 3 and 5)	$ 1,287,958	$ 632,678	$ 440,469	$ 2,361,105	$ 1,029,061	$ 3,390,166
Professional fees	99,616	262,874	170,684	533,174	121,832	655,006
Auditing fees	9,636	4,733	3,295	17,664	7,699	25,363
Depreciation and amortization	55,944	27,481	19,132	102,557	44,697	147,254
Donations and sponsorships	104,500	-	-	104,500	-	104,500
Legal	80,000	40,000	240,001	360,001	40,000	400,001
Meetings and travel	386,293	108,440	8,462	503,195	92,478	595,673
Equipment rental	58,017	25,707	5,940	89,664	13,879	103,543
Office services	74,705	54,760	15,257	144,722	30,372	175,094
Miscellaneous	12,402	6,092	4,241	22,735	9,909	32,644
Printing, design and layout	114,197	8,407	-	122,604	283	122,887
Advertising and media	104,781	-	-	104,781	-	104,781
Rent (Note 6)	126,820	62,297	43,371	232,488	101,328	333,816
Insurance, filing fees and taxes	-	-	-	-	28,885	28,885
IT/computer expenses	24,869	12,216	8,505	45,590	19,870	65,460
Sub-total	2,539,738	1,245,685	959,357	4,744,780	1,540,293	6,285,073
Allocation of overhead	272,219	133,720	93,096	499,035	(499,035)	-
Sub-total	2,811,957	1,379,405	1,052,453	5,243,815	1,041,258	6,285,073
Contributed legal services (Note 9)	65,856	32,927	197,563	296,346	32,927	329,273
TOTAL	**$ 2,877,813**	**$ 1,412,332**	**$ 1,250,016**	**$ 5,540,161**	**$ 1,074,185**	**$ 6,614,346**

See accompanying notes to financial statements.

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EXHIBIT D

AMERICA'S ESSENTIAL HOSPITALS

STATEMENT OF FUNCTIONAL EXPENSES
FOR THE YEAR ENDED DECEMBER 31, 2012

	Program Services					
	Member Services	Lobbying and Advocacy	Policy	Total Program Services	General and Administrative	Total Expenses
Salaries, taxes and benefits (Notes 3 and 5)	$ 878,509	$ 471,868	$ 460,636	$ 1,811,013	$ 1,091,853	$ 2,902,866
Professional fees (Note 4)	174,244	241,929	151,425	567,598	178,432	746,030
Auditing fees	9,166	4,923	4,806	18,895	11,392	30,287
Depreciation and amortization	23,904	12,839	12,534	49,277	29,709	78,986
Donations and sponsorships	79,050	-	-	79,050	-	79,050
Legal	80,000	40,000	240,000	360,000	40,000	400,000
Meetings and travel	256,751	64,585	26,889	348,225	136,802	485,027
Equipment rental	46,516	12,693	6,615	65,824	15,680	81,504
Office services	83,920	65,411	26,440	175,771	51,894	227,665
Miscellaneous	9,700	5,210	5,086	19,996	12,056	32,052
Printing, design and layout	63,294	5,445	-	68,739	3,020	71,759
Advertising and media	109,089	-	-	109,089	-	109,089
Rent (Note 6)	101,723	54,638	53,337	209,698	126,426	336,124
Insurance, filing fees and taxes	-	-	-	-	26,106	26,106
IT/computer expenses	34,778	18,680	18,236	71,694	43,224	114,918
Sub-total	1,950,644	998,221	1,006,004	3,954,869	1,766,594	5,721,463
Allocation of overhead	289,179	155,325	151,628	596,132	(596,132)	-
Sub-total	2,239,823	1,153,546	1,157,632	4,551,001	1,170,462	5,721,463
Contributed legal services (Note 9)	35,013	17,507	105,039	157,559	17,506	175,065
TOTAL	**$ 2,274,836**	**$ 1,171,053**	**$ 1,262,671**	**$ 4,708,560**	**$ 1,187,968**	**$ 5,896,528**

See accompanying notes to financial statements.

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EXHIBIT E

AMERICA'S ESSENTIAL HOSPITALS

STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012

	2013	2012
CASH FLOWS FROM OPERATING ACTIVITIES		
Changes in net assets	$ 1,485,304	$ 1,502,760
Adjustments to reconcile changes in net assets to net cash provided (used) by operating activities:		
Depreciation and amortization	147,254	78,986
Realized gain on sale of investments	(53,425)	(3,025)
Unrealized gain on investments	(194,964)	(245,572)
(Increase) decrease in:		
Accounts receivable	828,643	(860,067)
Due from Essential Hospitals Institute	1,333,234	(1,086,956)
Prepaid expenses	(16,234)	57,676
Assets held for deferred executive compensation plan	(209,941)	(221,749)
Increase (decrease) in:		
Accounts payable	(157,737)	(112,700)
Accrued expenses	304,984	19,678
Deferred membership dues	536,225	403,325
Other deferred revenue	46,150	(8,744)
Deferred rent liability	(36,211)	(28,949)
Post-retirement medical plan annuity	(2,074)	(4,410)
Deferred executive compensation plan liability	209,941	221,749
Net cash provided (used) by operating activities	4,221,149	(287,998)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of furniture, equipment and leasehold improvements	(300,012)	(37,885)
Purchases of investments	(1,617,504)	(2,144,383)
Proceeds from sale of investments	1,470,431	2,083,045
Net cash used by investing activities	(447,085)	(99,223)
Net increase (decrease) in cash and cash equivalents	3,774,064	(387,221)
Cash and cash equivalents at beginning of year	1,078,675	1,465,896
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 4,852,739	$ 1,078,675

See accompanying notes to financial statements.

1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES

Organization -

America's Essential Hospitals, formerly the National Association of Public Hospitals and Health Systems (NAPH), was incorporated on November 24, 1980, to provide a framework through through which public and nonprofit hospitals and health systems that share a common mission can cooperate with each other on a national scale; to promote analysis and research concerning matters that uniquely affect such hospitals and health systems; to provide information and assistance to its members with respect to such matters; to take appropriate action on administrative, regulatory, financial, legislative and judicial matters uniquely affecting such hospitals and health systems; and to maintain and enhance the organizational and financial strength of such hospitals and health systems so that they may better serve, represent and publicly state the needs and desires of their patients, employees, associated professionals and their community.

Basis of presentation -

The accompanying financial statements are presented on the accrual basis of accounting, and in accordance with FASB ASC 958, *Not-for-Profit Entities*.

Cash and cash equivalents -

America's Essential Hospitals considers all cash and other highly liquid investments, including certificates of deposit, with maturities of three months or less to be cash equivalents, and excluding money market funds held by investment managers in the amount of $18,404 and $216,027 for the years ended December 31, 2013 and 2012, respectively.

Bank deposit accounts are insured by the Federal Deposit Insurance Corporation ("FDIC") up to a limit of $250,000. At times during the year, America's Essential Hospitals maintains cash balances in excess of the FDIC insurance limits. Management believes the risk in these situations to be minimal.

Investments -

Investments are recorded at their readily determinable fair value and consist of money market funds, certificates of deposit, bonds and mutual funds. Realized and unrealized gains and losses are included in investment income in the Statements of Activities and Changes in Net Assets.

Accounts receivable -

Accounts receivable approximate fair value. Management considers all amounts to be fully collectable within one year. Accordingly, an allowance for doubtful accounts has not been established.

Furniture, equipment and leasehold improvements -

Furniture and equipment of $1,500 or more are capitalized and stated at cost. Furniture and equipment are being depreciated on the straight-line basis over the estimated useful lives of the related assets, generally three to five years. Leasehold improvements are amortized over the life of the lease using the straight-line basis.

1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES (Continued)

Membership dues -

Membership dues are billed to members annually. Revenue from membership dues is recognized in the year to which the dues apply. Dues payments, which have been received but not recognized, have appropriately been recorded as deferred revenue.

Unrestricted net assets -

Unrestricted net assets include unrestricted revenue and contributions received without donor-imposed restrictions. These net assets are available for the operation of America's Essential Hospitals and include both internally designated and undesignated resources.

Income taxes -

America's Essential Hospitals is exempt from Federal income taxes under Section 501(c)(6) of the Internal Revenue Code. Accordingly, no provision for income taxes has been made in the accompanying financial statements.

Uncertain tax positions -

For the years ended December 31, 2013 and 2012, America's Essential Hospitals has documented its consideration of FASB ASC 740-10, *Income Taxes*, that provides guidance for reporting uncertainty in income taxes and has determined that no material uncertain tax positions qualify for either recognition or disclosure in the financial statements.

The Federal Form 990, *Return of Organization Exempt from Income Tax*, is subject to examination by the Internal Revenue Service, generally for three years after it is filed.

Use of estimates -

The preparation of the financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Accordingly, actual results could differ from those estimates.

Functional allocation of expenses -

The costs of providing America's Essential Hospitals' programs and administration have been summarized on a functional basis in the Statements of Activities and Changes in Net Assets. Accordingly, certain costs have been allocated among the programs and supporting services benefited.

Risks and uncertainties -

America's Essential Hospitals invests in various investment securities. Investment securities are exposed to various risks such as interest rates, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the financial statements.

1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES (Continued)

Fair value measurement -

America's Essential Hospitals adopted the provisions of FASB ASC 820, *Fair Value Measurement*. FASB ASC 820 defines fair value, establishes a framework for measuring fair value, establishes a fair value hierarchy based on the quality of inputs (assumptions that market participants would use in pricing assets and liabilities, including assumptions about risk) used to measure fair value, and enhances disclosure requirements for fair value measurements. America's Essential Hospitals accounts for a significant portion of its financial instruments at fair value or considers fair value in their measurement.

Reclassification -

Certain amounts in the prior year's financial statements have been reclassified to conform to the current year's presentation. These reclassifications had no effect on the previously reported changes in net assets.

2. INVESTMENTS

Investments at December 31, 2013 and 2012 consisted of the following:

	2013 Fair Value	2012 Fair Value
Money market funds	$ 18,404	$ 216,027
Certificate of deposit	1,079,565	797,208
Bonds	712,581	811,805
Mutual funds	3,393,434	2,983,482
TOTAL INVESTMENTS	**$ 5,203,984**	**$ 4,808,522**

Investment income consisted of the following:

	2013	2012
Interest and dividends	$ 183,668	$ 96,046
Realized gain	53,425	3,025
Unrealized gain	194,964	245,572
Investment expenses	(36,595)	(34,708)
TOTAL INVESTMENT INCOME	**$ 395,462**	**$ 309,935**

3. POST-RETIREMENT MEDICAL PLAN ANNUITY

America's Essential Hospitals provides post-retirement medical benefits to the former Executive Director. The post-retirement benefit cost at December 31, 2013 and 2012 totaled $5,640 and $7,586, respectively.

3. POST-RETIREMENT MEDICAL PLAN ANNUITY (Continued)

Future benefit payments have been discounted at 4.09% and are expected to be paid as follows at December 31:

Year Ending December 31	
2014	$ 3,447
2015	3,590
2016	3,739
2017	3,896
2018	4,058
Thereafter	77,607
	$ 96,337

4. RELATED PARTY TRANSACTIONS

America's Essential Hospitals provides Essential Hospitals Institute with professional and administrative staffing, office space, equipment, furniture, office supplies and services, and other administrative support. Essential Hospitals Institute is a supporting organization to America's Essential Hospitals within the meaning of IRC Section 509(a)(3).

Costs are allocated between the two organizations based on actual expenditures or a percentage of salaries. America's Essential Hospitals' allocation of expenses was 50% for 2013 and 2012. During 2013 and 2012, costs allocated to Essential Hospitals Institute were $3,081,241 and $3,433,660, respectively, and the amounts paid by Essential Hospitals Institute to America's Essential Hospitals totaled $3,160,892 and $2,045,420, respectively. Both 2013 and 2012 amounts include a $700,000 contribution from America's Essential Hospitals to Essential Hospitals Institute to support uncovered Essential Hospitals Institute's labor and programmatic cost for research work and the Transformation Center.

At December 31, 2013 and 2012, Essential Hospitals Institute owed $55,007 and $1,388,241, respectively, to America's Essential Hospitals.

5. RETIREMENT PLANS

Effective April 30, 1997, America's Essential Hospitals adopted a profit sharing and 401(k) plan covering all employees who are at least 21 years of age and have completed 1,000 hours of service during their first twelve months of employment. Employer contributions to the profit sharing plan vest over a three-year period from the date of eligibility. Contributions in 2013 and 2012 totaled $417,200 and $294,841, respectively, and are included in accrued expenses on the Statements of Financial Position. Amounts were paid subsequent to the respective year ends. Of those amounts, $211,523 and $157,288, respectively, were allocated to Essential Hospitals Institute.

Additionally, America's Essential Hospitals maintains an IRC Section 457(b) plan for certain employees. Under this plan, participating employees can elect to defer their compensation within IRC guidelines. At December 31, 2013 and 2012, $461,757 and $340,320, respectively, are included in the assets held and deferred liability for the executive compensation plan accounts on the accompanying Statements of Financial Position. The 457(b) plan consists of employee contributions only.

5. RETIREMENT PLANS (Continued)

During 2002, the Board of Directors authorized an executive compensation plan for all senior level employees. Contributions in 2013 and 2012 totaled $95,690 and $80,321, respectively. At December 31, 2013 and 2012, $360,491 and $271,987, respectively, are included in the assets held and deferred liability for the executive compensation plan accounts on the accompanying Statements of Financial Position.

Effective July 1, 2012, America's Essential Hospitals established a non-qualified deferred compensation plan under Section 457(f), intended to provide supplemental retirement benefits to certain top level employees. America's Essential Hospitals has committed to fund a portion of the Plan with a minimum contribution of $44,000 on each anniversary until he becomes vested or terminates employment. The top level employees will be entitled to the Plan benefits upon remaining employed for the five-year vesting period, separating from service for death or disability, or experiencing an involuntary separation from service without reasonable cause. Total contributions to this 457(f) plan for the years ended December 31, 2013 and 2012 were $53,150 and $89,400, respectively. At December 31, 2013 and 2012, the balance of $44,000 is included in the assets held and deferred liability for the executive compensation plan accounts on the accompanying Statements of Financial Position. At December 31, 2012, the remaining $45,400 is included in accounts payable on the Statements of Financial Position and was subsequently paid into the Plan in January 2013.

6. LEASE COMMITMENT

America's Essential Hospitals' office space extends through December 31, 2015. The lease contains two months of abated rent in 2010 and an escalation clause with predetermined annual increases for the term of the lease. In addition, the landlord paid for improvements to the office space totaling $136,000.

In December 2011, America's Essential Hospitals modified its existing lease agreement for additional office space to support the expansion of Essential Hospitals Institute activities, a related party organization (see Note 4). The agreement expires in December 2015 and provides for landlord-paid leasehold improvements, which have been allocated to Essential Hospitals Institute. The new space is fully occupied by Essential Hospitals Institute staff and accordingly, all related rent expenses have been allocated to Essential Hospitals Institute for the year ended December 31, 2013.

Accounting principles generally accepted in the United States of America require that the total rent commitment should be recognized on a straight-line basis over the term of the lease. Accordingly, the difference between the actual monthly payments and the rent expense being recognized for financial statement purposes is recorded as a deferred rent liability in the Statements of Financial Position.

The following is a schedule, by years, of future minimum rental payments required under the operating lease:

Year Ending December 31,	
2014	$ 718,859
2015	738,026
	$ 1,456,885

6. LEASE COMMITMENT (Continued)

The amount of rent allocated to Essential Hospitals Institute at December 31, 2013 and 2012 totaled $316,089 and $288,253, respectively.

The amount of rent expense for America's Essential Hospitals at December 31, 2013 and 2012 totaled $333,816 and $336,124, respectively.

7. DESIGNATED OPERATING RESERVE

At December 31, 2013, $250,000 of general operating net assets were segregated as a Board designated operating reserve to fund future office relocation.

8. LINE OF CREDIT

On July 17, 2007, America's Essential Hospitals entered into a line of credit agreement with a local financial institution. Interest is at the bank's prime rate minus .5 percentage points. As of and for the years ended December 31, 2013 and 2012, there were no borrowings on the line of credit.

9. CONTRIBUTED SERVICES AND MATERIALS

In-kind contributions are recorded as revenue at their fair value when received. America's Essential Hospitals recognized $329,273 and $175,065 in donated legal services during the years ended December 31, 2013 and 2012, respectively.

10. COMMITMENTS

America's Essential Hospitals has entered into an employment agreement with its President and Chief Executive Officer through December 31, 2016, that provides for a minimum annual salary with increases based on annual performance reviews.

Additionally, America's Essential Hospitals is committed under agreements for conference space through the year 2015. The total commitments under the agreements are not determinable as it depends upon attendance and other unknown factors. There are cancellation penalties that would be due if the agreements were cancelled prior to the event date. The amount of the cancellation penalties increases through the date of the event.

11. FAIR VALUE MEASUREMENT

In accordance with FASB ASC 820, *Fair Value Measurement*, America's Essential Hospitals has categorized its financial instruments, based on the priority of the inputs to the valuation technique, into a three-level fair value hierarchy. The fair value hierarchy gives the highest priority to quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). If the inputs used to measure the financial instruments fall within different levels of hierarchy, the categorization is based on the lowest level input that is significant to the fair value measurement of the instrument.

11. FAIR VALUE MEASUREMENT (Continued)

Investments recorded in the Statements of Financial Position are categorized based on the inputs to valuation techniques as follows:

Level 1. These are investments where values are based on unadjusted quoted prices for identical assets in an active market America's Essential Hospitals has the ability to access.

Level 2. These are investments where values are based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, or model-based valuation techniques that utilize inputs that are observable either directly or indirectly for substantially the full-term of the investments.

Level 3. Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

Following is a description of the valuation methodology used for investments measured at fair value. There have been no changes in the methodologies used at December 31, 2013 and 2012.

- *Money market funds* - Fair value is equal to the reported net asset value of the fund.
- *Certificates of deposit* - Generally valued at original cost plus accrued interest, which approximates fair value.
- *Bonds* - Fair value is based upon current yields available on comparable securities of issuers with similar ratings, the security's terms and conditions, and interest rate and credit risk.
- *Mutual funds* - The fair value is equal to the reported net asset value of the fund, which is the price at which additional shares can be obtained.

The table below summarizes, by level within the fair value hierarchy, America's Essential Hospitals' investments as of December 31, 2013:

	Level 1	Level 2	Level 3	Total
Asset Class:				
Money market funds	$ 18,404	$ -	$ -	$ 18,404
Certificate of deposit	-	1,079,565	-	1,079,565
Bonds	-	712,581	-	712,581
Mutual funds	3,393,434	-	-	3,393,434
Total investments	3,411,838	1,792,146	-	5,203,984
Deferred executive compensation investments	866,248	-	-	866,248
TOTAL ASSETS	$ 4,278,086	$ 1,792,146	$ -	$ 6,070,232
Liability Class:				
Deferred executive compensation liability	$ (866,248)	$ -	$ -	$ (866,248)
Post-retirement medical plan annuity	-	-	(96,337)	(96,337)
TOTAL LIABILITIES	$ (866,248)	$ -	$ (96,337)	$ (962,585)

11. FAIR VALUE MEASUREMENT (Continued)

The table below summarizes, by level within the fair value hierarchy, America's Essential Hospitals' investments as of December 31, 2012:

	Level 1	Level 2	Level 3	Total
Asset Class:				
Money market funds	$ 216,027	$ -	$ -	$ 216,027
Certificate of deposit	-	797,208	-	797,208
Bonds	-	811,805	-	811,805
Mutual funds	2,983,482	-	-	2,983,482
Total investments	3,199,509	1,609,013	-	4,808,522
Deferred executive compensation investments	656,307	-	-	656,307
TOTAL ASSETS	$ 3,855,816	$ 1,609,013	$ -	$ 5,464,829
Liability Class:				
Deferred executive compensation liability	$ (656,307)	$ -	$ -	$ (656,307)
Post-retirement medical plan annuity	-	-	(98,411)	(98,411)
TOTAL LIABILITIES	$ (656,307)	$ -	$ (98,411)	$ (754,718)

Level 3 Financial Assets

The following table provides a summary of changes in fair value of America's Essential Hospitals' financial liability for the years ended December 31, 2013 and 2012:

	Post-Retirement Medical Plan Annuity
Beginning balance as of January 1, 2012	$ 102,821
Net periodic costs	(7,586)
Net change in value	3,176
Balance as of December 31, 2012	98,411
Net periodic costs	(5,640)
Net change in value	3,566
BALANCE AS OF DECEMBER 30, 2013	$ 96,337

12. SUBSEQUENT EVENTS

In preparing these financial statements, America's Essential Hospitals has evaluated events and transactions for potential recognition or disclosure through April 8, 2014, the date the financial statements were issued.

Attachment I

2014 Projection vs. Budget

	col 1	col 2	col 3	col 4
	2013 Audit	**2014 Revised Budget**	**2014 Projection**	**Projection vs. Budget**
INCOME:				
Membership dues	$ 4,627,383	$ 5,153,100	$ 5,338,000	$ 184,900
UHC Membership dues	$ 2,831,400	$ 2,992,000	$ 2,992,000	$ (0)
UHC sponsorships	$ 250,000	$ 158,000	$ 158,000	$ -
Other sponsorships	$ 204,495	$ 245,000	$ 245,000	$ -
Annual conference	$ 112,235	$ 136,600	$ 136,600	$ -
Waiver seminar	$ -	$ 25,600	$ 25,600	$ -
TOTAL INCOME	**$ 8,074,913**	**$ 8,710,300**	**$ 8,895,200**	**$ 184,900**
EXPENSE:				
RETAINER	$ 400,000	$ 400,000	$ 400,000	$ -
SALARIES & FRINGES	$ 3,390,166	$ 4,140,000	$ 4,140,000	$ -
Policy	$ 175,894	$ 246,700	$ 261,100	$ (14,400)
Advocacy	$ 439,371	$ 456,000	$ 464,700	$ (8,700)
Member services	$ 191,307	$ 232,500	$ 253,500	$ (21,000)
Consulting/professional fees	$ 147,195	$ 135,000	$ 135,000	$ -
Information technology	$ 67,588	$ 114,000	$ 114,000	$ -
Rent	$ 339,283	$ 384,200	$ 376,000	$ 8,200
Office expenses/equipment rental	$ 142,283	$ 223,100	$ 223,100	$ -
Communications	$ 148,245	$ 307,600	$ 307,600	$ -
Conferences	$ 456,255	$ 612,200	$ 568,200	$ 44,000
Travel and professional development	$ 68,562	$ 125,500	$ 125,500	$ -
Taxes, Insurance and miscellaneous	$ 61,031	$ 69,000	$ 69,000	$ (0)
Depreciation/amortization	$ 147,254	$ 75,500	$ 75,500	$ 0
Fellows Program	$ -	$ -	$ -	$ -
Project development/moving expenses	$ -	$ 312,000	$ 312,000	$ -
Contribution /support to Institute	$ 700,000	$ -	$ -	$ -
TOTAL EXPENSES	**$ 6,874,434**	**$ 7,833,300**	**$ 7,825,200**	**$ 8,100**
Changes in net assets before funding from reserves	**$ 1,200,479**	**$ 877,000**	**$ 1,070,000**	**$ 193,000**
Other Items funded from reserves:				
Rebranding (including depreciation on website)	($110,636)	$ (100,000)	$ (100,000)	$ -
Changes in net assets, after funding from reserves (operating surplus)	**$ 1,089,843**	**$ 777,000**	**$ 970,000**	**$ 193,000**
Non-Operating Income:				
Interest/dividend income	$ 147,325	$ 50,000	$ 50,000	$ -
Realized capital gains/(losses)	$ 3,762	$ -	$ -	$ -
Unrealized gains/(losses)	$ 244,375	$ -	$ -	$ -
Total non-operating income/(loss)	**$ 395,462**	**$ 50,000**	**$ 50,000**	**$ -**
Changes in net assets, after non-operating income	**$ 1,485,305**	**$ 827,000**	**$ 1,020,000**	**$ 193,000**
NET ASSETS:				
Prior year net assets	$ 5,274,045	$ 6,759,350	$ 6,759,350	$ -
Change in net assets	$ 1,485,305	$ 827,000	$ 1,020,000	$ 193,000
Total net assets after funding of special projects	**$ 6,759,350**	**$ 7,586,350**	**$ 7,779,350**	**$ 193,000**
Contribution to restricted net assets:				
Office relocation (restricted net assets)	$ (250,000)	$ (100,000)	$ (100,000)	$ -
Total contribution to restricted net assets	**$ (250,000)**	**$ (100,000)**	**$ (100,000)**	**$ -**
Summary of total net assets:				
Unrestricted net assets	$ 6,509,350	$ 7,236,350	$ 7,429,350	$ 193,000
Restricted net assets for office relocation	$ 250,000	$ 350,000	$ 350,000	$ -
Total net assets	**$ 6,759,350**	**$ 7,586,350**	**$ 7,779,350**	**$ 193,000**
Reserve %	98%	97%	99%	
Operating margin, excluding invest gains	13%			
Operating margin, including invest gains	18%			

AMERICA'S ESSENTIAL HOSPITALS

DATE June 16, 2014
TO Board of Directors
FROM Michael Belzer, MD, Education Committee Co-Chair
RE Education Committee Report MEMORANDUM

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

Annual Conference

- **VITAL2014**
  One of the committee's goals for this conference was to broaden participation. In support of the goal, this year's annual conference features several new session formats, including 30-minute mini-sessions that feature focused case studies, and five-minute Rapid-Fire presentations. All programming is organized into four tracks: executive leadership, clinical leadership, finance, and quality and patient safety.

  Another committee goal for the conference was to provide avenues for focused networking. You will see new name badge ribbons available to designate various groups within the membership and provide a visible mechanism to connect with folks. We also have in-person interest group meetings on Wednesday afternoon for participants to gather around the topics of philanthropy, medical leadership, and the 340B Drug Pricing Program. Also on Wednesday, the opening reception will feature designated areas for segments of the membership to network in an informal setting.

  During this year's conference, the education committee is taking on two new roles and raising the visibility of the volunteers. First, committee members in attendance will serve as moderators for select breakout sessions. Second, committee members will serve as ambassadors to first-time attendees, providing the new participants with an orientation to the association and the conference.

  As of June 3, 216 individuals were registered for the conference. An updated registration count will be provided during the board meeting.

- VITAL2015
  Next year's annual conference will be in San Diego, June 24-26. As planning for the conference begins, the committee supports staff's suggestion to conduct a call for proposals (CFP) process that will solicit members for presentation proposals to be considered for the program. The CFP will lead to more engaged members, the surfacing of new topics and case studies, and a more robust program. It is anticipated that about half the program will come from the CFP and half the program will be invited panels. Staff will accept proposals between mid-September and mid-November, with the committee evaluating and selecting proposals in mid-December.

Section 1115 Delivery System Reform Incentive Payment (DSRIP) Waivers

As reported during the last board meeting, staff has organized a comprehensive educational work plan focusing on section 1115 waivers to include a webinar series, several sessions during the annual conference, and two written products: a policy brief and a research brief. The waiver webinar series has been organized as case studies around the impact of waivers on quality improvement at hospitals in three different waiver states. Additionally, an in-person meeting has been schedule for September 29 at the Hilton Chicago O'Hare Airport. This fee-based, one-day program targets chief medical officer/chief financial officer teams and will feature presentations on waiver trends, financing, and clinical improvement. More details on the program will be available during the board meeting.

Innovations Summit

The 2014 Innovations Summit is scheduled for October 29, in Washington, DC. This year's summit focuses on population health and social networks. The confirmed keynote speaker is Nicholas Christakis, MD, PhD, a physician and social scientist who directs the Human Nature Lab at Yale University. His research focuses on how social networks affect health and health care and implications for policy and public health. He is the co-author of *Connected: The Surprising Power of Our Social Networks and How They Shape Our Lives.* The program will also feature Rapid-Fire sessions from five or six essential hospitals showcasing their efforts to improve population health in their communities.

Fellows Program

During the third and final session of the 2013 Fellows Program, participants advocated to key legislators on Capitol Hill on behalf of America's Essential Hospitals. Fellows also had the opportunity to present and hear from each other's leadership lessons learned through the work on their year-long program projects.

During session I of the 2014 Fellows Program, the new class will strengthen the skills needed to lead adaptive change in complex environments. Participants will have the opportunity to learn the adaptive leadership framework developed by Ron Heifetz and

Marty Linsky, of Harvard University., The framework helps individuals and organizations through consequential change by confronting the status quo and identifying technical and adaptive challenges.

Webinars

The 2014 schedule of webinars continues to be robust. For the second half of the year, topics will include the 340B program, patient and family centered care, HCAHPs, Medicaid expansion, and chronic disease management.

AMERICA'S ESSENTIAL HOSPITALS

DATE June 16, 2014
TO Board of Directors
FROM David Lopez, Membership Committee Chair
RE Dues Restructuring

MEMORANDUM

Introduction

The membership committee recommends a new dues structure. We are grateful for the time the board has already put into this issue, and many of your ideas are reflected below. Our objectives are to create a fair and equitable dues structure that fosters continual growth and financial strength.

Overview

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

We also recognize there is strength in numbers. With members in 34 states and the District of Columbia, we know the value of our collective voice and aim to create a membership model that attracts organizations from all 50 states, strengthening our ability to represent hospitals serving the most vulnerable. Any dues model also needs to reflect the prospect of some larger, multistate systems joining the association and ensuring these systems pay their fair share.

Staff from America's Essential Hospitals worked with Avenue M Group, LLC, to plan and identify the best way to restructure dues. We examined numerous membership dues models, including the option of maintaining our current model. The process included an environmental assessment, member survey, a study of available hospital data, and modeling of multiple dues options on the individual member level.

The values guiding this work included the following:

- Extreme swings in dues should be dampened as much as possible.

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

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

Proposed Dues Structure

The committee recommends a dues structure based on the following methodology:

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

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

Figure 1

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

Financial Impact

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

Figure 2

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

**revenue based on:*

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

***revenue based on:*

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

Comparative Market Data

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

Figure 3

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

Market Testing

Since the last board meeting, Avenue M conducted telephone interviews with nine leaders from member hospitals and health systems whose proposed dues fell in the $45,000 to $100,000 range to obtain feedback on the proposed dues structure. At the beginning of the interview, the current structure and proposed model were described to participants. Overall, participants support and understand the need for an equity based model. Key findings also include the following:

- Several participants asked if the new dues structure would generate more revenue and where that additional revenue would be directed.
- Several participants expressed concern that the new structure would drive larger systems out of the organization, substantially impacting revenue and political influence.
- Participants recognized that while the percentage increase can be perceived as too high, in dollar terms it is not a significant increase.
- Members would like to see the association make the case for the new structure at the CEO level.

Based on these findings, America's Essential Hospitals is confident in moving forward with the proposed dues structure and, upon roll out, will tailor communications to address the survey findings. As such, America's Essential Hospitals will need to

- explain in detail why the new structure is structured into tiers based on expenses as opposed to revenue, as well as the method for ensuring the expense data is accurate;
- communicate the motivation for the change and what the association hopes to achieve with the revenue derived from the new structure;

- demonstrate that the new structure will not give undue influence to larger organizations, and continue to recognize the contribution of all members, regardless of size; and
- communicate how the phase-in of the new structure demonstrates sensitivity to members' financial conditions.

Next Steps

Pursuant to the discussion at the last board meeting, the committee seeks final board approval of the new dues structure.

If there is an affirmative vote, our formal communication to all members will begin with Bruce Siegel's speech to the membership here, in San Antonio. That will be followed with aggressive, individual, member-wide communication in July. The association will send 2015 dues invoices in early November.

AMERICA'S ESSENTIAL HOSPITALS

DATE June 16, 2014
TO Board of Directors
FROM William B. Walker, MD, Chair, Policy Advisory Committee
RE Policy Advisory Committee Report MEMORANDUM

On behalf of the policy advisory committee (PAC), I provide you with this update of the committee's activities.

Over the past several months, the committee has developed principles to which state Medicaid alternative payment models should adhere. Growing state interest in alternative payment models, such as patient-centered medical homes and accountable care organizations (ACOs), spurred our development of these principles. The committee is recommending that the board approve the draft principles in this report. Following board approval, the principles will be shared broadly with America's Essential Hospitals members with the hope that members can use the principles in their work to educate and engage state and federal policymakers. The principles will also assist America's Essential Hospitals staff in federal advocacy. A description of the scope of this work is outlined below. The draft principles are included in Appendix A and a list of PAC members is included in Appendix B.

Interest on the part of states to implement alternative payment arrangements reflects, in part, similar growing interest in securing Medicaid waivers that include a delivery system reform component, as well as renewing existing waiver programs. Medicaid alternative payment models vary widely in their design, often building on a state's existing payment framework and delivery pathway. Alternative Medicaid payment models include a range of approaches, such as patient-centered medical homes, episodes of care, bundled payments, ACOs, global budgets, and dual-eligible integration models. These alternative payment models all hold the promise to fundamentally change the way providers are paid for delivering health care services to Medicaid patients.

States with alternative payment models in place have taken different approaches, and our members have reported both positive and negative experiences with these programs. For example, Minnesota was an early leader, passing a state law in 2008 to improve affordability, expand coverage, and improve the overall health of state residents, and following up with a law that mandated the testing of alternative delivery

systems, including ACOs. In 2012, Arkansas began to test the use of a shared savings model based on episodes of care to try to drive down the costs of care while improving quality. Massachusetts has firmly woven payment system transformation into its delivery system transformation waiver, and hospitals there are undertaking major projects to align with physicians to form ACOs and integrated care organizations, among other efforts.

Some of our members participating in existing alternative payment models report that they have successfully taken on the increased risk that comes with managing a population's health and health care. Others have reported discord with their states when the state's primary goal to reduce health care costs has restricted hospitals' abilities to also improve patient care. Some of our members have reported situations in which states have rushed to start programs before they truly had the capacity to do so. For example, some states did not have the data systems in place to provide adequate information on the patients assigned to each hospital under an ACO program.

The principles recommended by the policy advisory committee seek to address not only the components of a successful alternative payment arrangement, but also the process by which an alternative payment model should be designed and implemented. I welcome the board's review of the principles and look forward to receiving your feedback.

Appendix A - Draft Principles on Medicaid Alternative Payment Models

Members of America's Essential Hospitals provide access to care for the most vulnerable. Through their work with underserved populations, these essential hospitals have evolved into comprehensive, integrated systems of care that are uniquely focused on the needs and challenges of the low-income population. These hospital systems also are committed to a diverse set of health care missions, including training future care professionals, providing trauma care and other intensive services not otherwise available, and improving community health through extensive primary care networks and public health initiatives. As such, these hospital systems are essential to their communities and a critical partner to federal, state, and commercial payers as they consider adopting alternatives payment models (APMs). When policymakers begin to deliberate various APMs, we urge them to consider the following principles.

1. The goal of APMs must be broader than cost savings alone and should strive to improve patient care, particularly the coordination of care, and advance the health care delivery system. Any insights and successes learned from participating in APMs should be shared widely and regularly so that all may benefit.

2. APMs should be designed to be flexible to fit the needs of patients, providers, communities, and states. APMs must support providers' efforts to transform their care delivery systems by providing additional resources for system transformation and adequate payment for all services. States and payers should design APMs to work in tandem with existing initiatives to avoid duplication and minimize cost of participation. In addition, savings from administrative efficiencies realized by states, payers, and providers should be used to enable providers to further patient care needs.

3. APMs should be developed with input from all stakeholders and implemented with a transition period to allow for a successful evolution to the new system. Such a phased-in approach must include safeguards to protect participating providers against unanticipated adverse risk during the transition. In fact,

experience with APMs could be used as an interim step toward readiness for full-risk arrangements.

4. Before launching APMs, states, payers, and providers all must have the necessary data analysis and sharing capabilities to fully implement the program. States and payers must share with providers accurate information on patients assigned to them under any risk-based arrangement and the costs of caring for these patients in all settings in the community. Such data should also be used to support appropriate attribution and alignment efforts to ensure that all APM participants have an equal chance of success.

5. APMs should include incentives that improve quality of care, reduce disparities, and encourage providers to deliver patient-centered care. APMs that assess providers on quality of care must take into account the effects that social determinants of health have on patient care and outcomes and incorporate appropriate risk adjustment methodologies when implementing these assessment programs.

6. APMs must be designed with complementary incentives for both providers and patients so that patients are just as engaged as providers in reducing costs. If providers are assuming risk for managing the health and health care costs of a population, then they must have some meaningful influence over where individuals seek care.

7. APMs that include or focus on special populations, such as dual-eligibles, individuals with complex medical needs, or individuals with behavioral health needs, must recognize the specific challenges and needs of those populations, which are costly to address and often are unreimbursed or under-reimbursed.

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

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

Kirk Calhoun, MD
President and CEO
UT Northeast

Jeff Feasel
President and CEO
Halifax Health

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

John M. Haupert
CEO
Grady Health System

Wright L. Lassiter, III
CEO
Alameda Health System

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

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

Nancy Schlichting
CEO
Henry Ford Health System

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

Patrick Wardell
President and CEO
Cambridge Health Alliance

AMERICA'S ESSENTIAL HOSPITALS

DATE June 16, 2014
TO Board of Directors
FROM Beth Feldpush, DrPH, Senior Vice President of Policy and Advocacy
RE Policy/Advocacy Update

MEMORANDUM

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

Continued Success Delaying Medicaid DSH Cuts and Implementation of DSH Study

In the days leading up to the board's last meeting, America's Essential Hospitals scored a legislative victory by winning a third year of delay in cuts to Medicaid disproportionate share hospital (DSH) payments. The DSH cuts delay came in legislation that temporarily patched Medicare's sustainable growth rate (SGR) to avert deep reductions in physician payments. Medicaid DSH cuts now will begin October 1, 2016.

America's Essential Hospitals worked to include in the legislation a requirement for annual reports by the Medicaid Payment and Access Commission (MACPAC) on the future need for Medicaid DSH. The reports – which will begin in 2015 – must include information regarding levels of uncompensated care in each state, uninsurance by state, and Medicaid losses by hospital. We believe these reports will help us make the case for further delays or repeal of the DSH cuts set to begin in 2016. We have already begun meeting with MACPAC on this study, as we want to ensure the commission fully understands the work of essential hospitals and the full breadth of services you provide as MACPAC shapes its report. In particular, MACPAC staff members have commented that they will look to America's Essential Hospitals' policy staff as subject matter experts as they determine the data sets and analytics to use in the study.

Although the congressional committees of jurisdiction had made unprecedented progress this spring in coming to an agreement on how to replace the SGR, they could not find agreement on how to pay for it. The current patch, which is the 17th temporary fix to the formula, is effective until April 1, 2015. In the same law, Congress also delayed the roll-out of ICD-10 codes until October 1, 2015.

Laying the Groundwork for Continued Support

Because we expect little other legislation this election year, one of our key advocacy goals of 2014 is to continue educating policymakers about what essential hospitals do and what distinguishes our members from other providers **(see characteristics box below).** This is critical as we lay the groundwork to seek continued delay of the Medicaid DSH cuts. Over the next several years, as coverage expansion continues and Medicaid DSH cuts are delayed or not yet at their fullest, we believe some may argue that essential hospitals are sitting in a favorable financial position. We know millions will remain uninsured and largely continue to seek care at essential hospitals. We know many states have not yet expanded their Medicaid programs, and even among those that have expanded, Medicaid remains a poor payer. We know some individuals who gain coverage through the marketplaces, and even some individuals gaining new Medicaid coverage, may face increased cost-sharing obligations they cannot meet. We know that you provide your communities with essential services for which you are not fully reimbursed—training tomorrow's clinicians and providing trauma care and other specialized services, for example. We will embark on a messaging campaign throughout the remainder of this year to clarify and solidify for policymakers the role essential hospitals fill and proactively rebut negative perceptions about the financial status of essential hospitals.

CHARACTERISTICS OF AN ESSENTIAL HOSPITAL

Provide care to the vulnerable,
particularly the uninsured and Medicaid recipients

+

Train the next generation of clinicians	Deliver comprehensive, coordinated care to communities	Provide specialized, lifesaving services, such as trauma and neonatal intensive care	Advance public and population health

Member Education Efforts and Advocacy on Delivery System Transformation Waivers

We continue to focus on member education and regulatory advocacy around Medicaid delivery system transformation waivers. At Vital2014, we are releasing a Medicaid waiver policy brief outlining the evolution of Medicaid waivers that incentivize and reward delivery system reform. We are amid a series of webinars featuring clinical quality improvement results from hospitals in different waiver states. The programming for Vital2014 consists of several sessions on waiver programs. And, this fall, we will pilot

a new member education and engagement initiative by offering a one-day, in-person leadership summit on state Medicaid waivers.

Supporting Equity in Quality Measurement

A large body of emerging scientific evidence shows that sociodemographic factors (e.g., age, race, ethnicity, primary language) and socioeconomic status (e.g., income, education, occupation) can influence health outcomes. These findings are of particular importance in pay-for-performance programs that reward hospitals for providing high-quality care and penalize them for lower quality. America's Essential Hospitals has long supported the inclusion of sociodemographic and socioeconomic factors in the risk-adjustment models of outcomes measures when conceptual and empirical evidence warrants it. We believe doing so will improve the science of performance measurement by increasing precision and delivering more accurate information to providers, payers, and the public. And, if these factors are not taken into consideration in pay-for-performance programs, hospitals that serve vulnerable populations could be unfairly penalized in this process, which could then worsen disparities in care.

An acknowledgement of the growing body of literature examining these issues is beginning to generate discussion in policy circles in Washington, DC. The National Quality Forum (NQF), the entity that reviews and endorses quality measures for use in national programs, is reviewing its long-standing position that quality measures should not be risk-adjusted to account for socio-demographic factors and may revise its position. (At the board meeting, David Engler, PhD, director of Essential Hospitals Institute, will lead a discussion on the NQF's work.)

America's Essential Hospitals supports legislation sponsored by Rep. Jim Renacci (R-OH) that would guarantee hospitals caring for vulnerable patients are not unfairly penalized by the hospital readmissions reduction program (HRRP). The legislation would direct the secretary of health and human services to adjust the readmissions measures used for the HRRP by the proportion of dually eligible patients (a proxy for counting low-income patients) served by hospitals. We sent a support letter to Rep. Renacci when his legislation was introduced in March. We also recently urged our members to advocate that their representatives sign onto a dear colleague letter spearheaded by Rep. Renacci to the U.S. Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS), encouraging those agencies to refine the readmissions measures methodology to account for hospital patients' socio-economic status.

On the Senate side, America's Essential Hospitals has been working with Sen. Joe Manchin (D-WV) on separate legislation that would go farther than the Renacci bill and require CMS to risk-adjust the actual methodology of the readmissions measure for sociodemographic factors. We expect the Manchin legislation to be introduced by the time of the board meeting, and we will discuss it in detail then.

Engagement on Contracts with Qualified Health Plans through the Exchanges

Ensuring members' full participation in the federally facilitated exchanges (marketplaces) continues to be a focus for America's Essential Hospitals. We have commented numerous times to the White House, to CMS leadership, and to CMS staff about the need for stronger rules on exclusion of essential hospitals from the networks of qualified health plans (QHPs). Since the last meeting of this board, we provided additional comments to CMS and the departments of Labor, Health and Human Services, and the Treasury in response to a notice of proposed rulemaking on the quality rating systems in the marketplaces and a request for information on the provider nondiscrimination provision of the ACA.

In its comment letters, America's Essential Hospitals urged the agencies to protect consumer access to essential community providers (ECPs) upon whom they already rely for health care services. The association urged the agencies to use measures that are risk-adjusted for socioeconomic factors to accurately represent the quality of care at ECPs. In addition, the association asked the agencies to ensure that health plan issuers include essential hospitals in their networks and do not unfairly offer lower rates to these hospitals based on undefined market factors.

Options for Addressing Uncompensated Care in the Exchanges

Ensuring the success of coverage expansion through the marketplace can have a positive impact on members of America's Essential Hospitals. Toward that end, the association commented on recent CMS guidance on the ability of third parties to provide premium assistance on behalf of individuals eligible for marketplace coverage. Although the guidance doesn't address the ability of hospitals to provide this assistance directly, the association strongly urged CMS to permit such payments. In addition, America's Essential Hospitals published a policy brief updating guidance issued by CMS to date and highlighting the importance of permitting providers to offer premium assistance directly. We continue to work on this issue for our members and expect to issue in the coming weeks a companion piece around the topic of cost sharing assistance for individuals eligible for marketplace coverage.

Protecting Hospitals' Medicare Payments

As part of this year's rulemaking process for setting Medicare inpatient hospital payments for fiscal year 2015, America's Essential Hospitals spearheaded an effort to ensure that data used for determining hospitals' Medicare DSH payments in the future are as accurate and reliable as possible. Specifically, we provided comprehensive comments to CMS on the accuracy of the data elements captured on worksheet S-10 of the Medicare cost report.

In addition, the association continues to advocate on behalf of its members to ensure that the hospital value-based purchasing, readmissions reduction, hospital-acquired condition reduction, and electronic health records incentive payment programs do not unfairly disadvantage essential hospitals.

Expecting 340B Regulations

In response to congressional criticism that it does not provide sufficient oversight of the 340B Drug Pricing Program, the Health Resources and Services Administration (HRSA) is drafting a large regulation, referred to as the "mega-reg," that would put into formal regulation all of the program guidance for administration of 340B. Although HRSA has not said much openly about the contents of the proposed rule, we believe it will contain several controversial provisions. We expect HRSA to provide program guidance on hospital eligibility for the 340B program, the definition of a 340B patient, and the use of contract pharmacies. We also believe HRSA may favorably address the issue of the current delay in enrollment of new outpatient clinics pending the filing of a Medicare cost report.

We had expected the rule to be released in June. But in late May, the U.S. District Court for the District of Columbia vacated a separate final rule promulgated by HRSA on orphan drug pricing for critical access hospitals, freestanding cancer hospitals, rural referral centers, and sole community hospitals. In its ruling, the court granted an injunction that prevents HHS from implementing that rule and held that the rule was outside the scope of the agency's rulemaking authority. America's Essential Hospitals, along with two other national organizations, filed an amicus brief while the case was pending that supports HHS' final rule.

With the court's ruling calling into question HRSA's regulatory authority over the 340B program, the status of the mega-reg is unclear at this time. HRSA is most certainly reviewing the proposed rule language to determine if others could argue that any changes it proposes are outside of its authority. The agency may or may not decide to go forward with the release of the mega-reg at this time. The agency also may choose to appeal the court's decision. America's Essential Hospital will continue to monitor these events and keep members informed.

If and when the rule is released, America's Essential Hospitals will educate members with email analyses and a webinar on the rule's contents. Also, as we develop formal comments on the rule, we will solicit input from members, including our newly formed 340B steering committee, 340B interest group, and government relations professionals group.

AMERICA'S ESSENTIAL HOSPITALS

DATE June 16, 2014
TO Board of Directors
FROM David Engler, PhD, Senior Vice President of Leadership and Innovation
Ashley Ferguson, MPH, MA, Project Associate
RE National Quality Forum's Report on Risk Adjusting Performance Measures for Socioeconomic Factors

MEMORANDUM

The Centers for Medicare & Medicaid Services charged the National Quality Forum (NQF) to address "what, if anything should be done about sociodemographic factors in relation to outcome performance measurement." Current NQF policy does not allow for adjustment of performance measures for sociodemographic factors, a term NQF uses to explain a variety of socioeconomic (e.g., income, education, occupation) and demographic (e.g., age, race, ethnicity, primary language) factors.

In October 2013, NQF convened a 26-member expert panel. Three participants on the expert panel are from members of America's Essential Hospitals. The panel is co-chaired by David Nerenz, PhD, of Henry Ford Health System. Also on the panel are Nancy Garrett, PhD, of Hennepin County Medical Center, and Nancy Sugg, MD, of Harborview Medical Center. The U.S. Department of Health and Human Services has funded this project.

The expert panel's formation and its report follow a large body of emerging evidence that sociodemographic factors can influence health outcomes. America's Essential Hospitals has published a partial list of this research on its website.

The published report drafted by the expert panel and posted by NQF on March 18, 2014, made eight recommendations. The most notable recommendation was **for NQF to change its current policy to endorse performance measures used in accountability applications (e.g., public reporting, pay-for-performance) that risk adjust for both clinical and sociodemographic patient factors.** America's Essential Hospitals posted public comment in support of the draft recommendations and the use of sociodemographic factors in risk models for these reasons:

- creates a more accurate picture of performance
- levels the playing field, especially for providers that treat vulnerable populations
- improves the value and content of public reporting
- Without adjustment, our members would be unfairly disadvantaged in transparency efforts to compare quality, and in accountability models, which carry payment penalties.
- improves the science of performance measurement

Eight organizations out of 160 that commented publicly on the report's recommendations opposed it. In summary, the opposition argued that sociodemographic adjustment would

- mask disparities;
- give no expectation for improvement;
- cannot be done due to data limitations; and
- should be addressed with a payment policy, as it is not a performance measure issue.

The expert panel is now revising its initially published draft report to reflect public comments in April. The report will then move to NQF's consensus standards approval committee for review and a vote. The NQF board of directors will review the report and either ratify or revise it at the board's next in-person meeting, July 23.

Risk adjusting performance measures used in accountability models for sociodemographic factors is an extremely important topic for our members. It is also receiving a large amount of public and media attention. America's Essential Hospitals' board will discuss the expert panel's recommendations and next steps, and will be briefed on current legislative proposals.

Attachment A

Comment Break Down:

160	organizations (or individuals)
140	commenters who supported the recommendations
8	commenters who strongly opposed the recommendations
7	commenters who provided mixed comments or reservations
5	commenters who supported most recommendations but opposed recommendation 7 - NQF having a role in guidance on implementation

Organizations Opposed:

Centers for Medicare & Medicaid Services
Consumers Union/Consumer Reports
Mathematica Policy Research
National Committee for Quality Assurance
National Partnership for Women & Families
St. Louis Area Business Health Coalition
The Leapfrog Group
Yale/HRET

Organizations Supporting:

AAMC
Alabama Hospital Association
American Academy of Dermatology
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Association of Neurological Surgeons
American College of Cardiology
American College of Emergency Physicians
American College of Surgeons
American Geriatrics Society
American Hospital Association
American Medical Association
American Medical Group Association
American Society of Clinical Oncology
America's Essential Hospitals
America's Health Insurance Plans
AMRPA
Armstrong Institute for Patient Safety and Quality at Johns Hopkins University
Association of Asian Pacific Community Health Organizations (AAPCHO)
Association of Community Affiliated Plans
Barnes-Jewish Hospital
Baylor Scott & White Health
Bi-State Primary Care Association
Bon Secours Baltimore Health System
Boston Medical Center
California Health Care Safety Net Institute
California Hospital Association
California Hospital Patient Safety Organization
California Pan-Ethnic Health Network (CPEHN)
California Primary Care Association
Carilion Clinic
Catholic Health Association of the United States
Cedars-Sinai Health System
Center for Health Care Quality
Center for Health Equity and Wellness at Adventist HealthCare
CHI
Children's Hospital & Research Center Oakland

Children's Hospital Association
CHRISTUS Health
Cigna-Health Spring
ClearWay Minnesota
Cleveland Clinic
Community Catalyst
Community Healthcare Association of New York State
Contra Costa County Health Services
Crozer-Keystone Health System
Duke University Health System
Einstein Healthcare Network
Emory Healthcare
Federation of American Hospitals
Florida Hospital
Froedtert and Medical College of Wisconsin
Georgia Regents Medical Center
GlaxoSmithKline
Greater New York Hospital Association
Greenville Health System
Harborview Medical Center
Harvard University Medical School
Healthcare Association of New York State (HANYS)
HealthPartners
Heart Rhythm Society
Hennepin County Medical Center
Henry Ford Health System
Illinois Academy of Family Physicians
Indiana Primary Health Care Association
Infectious Diseases Society of American (IDSA)
Iowa Primary Care Association
Johns Hopkins University Armstrong Institute for Patient Safety and Quality
Kentucky Primary Care Association
Kokua Kalihi Valley
Loyola University Health System - Center for Clinical Effectiveness
Maryland Hospital Association
Maryland Office of Minority Health and Health Disparities
Mass General Hospital
Massachusetts General Hospital
Medical Center Health System
Medical University of South Carolina
MedStar Health
Mercy Health System SEPA
Meridian Health
Michigan Primary Care Association
Minnesota Safety Net Coalition
Missouri Hospital Association
MN Assoc of Community Health Centers
Montefiore Medical Center
Mount Sinai Health System
National Association of Community Health Centers
National Hispanic Medical Association
New Jersey Hospital Association
NewYork-Presbyterian
Next Wave
Northwestern Memorial HealthCare
OhioHealth
Oregon Primary Care Association
Orlando Health
Partners HealthCare System, Inc.
Pharmacy Quality Alliance
PhRMA
Premier healthcare alliance
Presence Health
RBS
Regions Hospital/HealthPartners
Reliant Medical Group
Rome Memorial Hospital
Rural Wisconsin Health Cooperative
Rutgers University
Saint Anthony Hospital
Sentara Healthcare
Service Employees International Union
SNP Alliance
Society of Hospital Medicine
SSM Health Care
St. Louis Regional Health Commission
Stanford University
Temple University Health System
The Hospital & Healthsystem Association of Pennsylvania (HAP)
The OSU Medical Center
Trinity Health
Truman Medical Centers
UAB Health System
UC Office of the President
UHC
University Hospitals Health System
University Medical Center of Southern Nevada
University of Colorado School of Medicine
University of Massachusetts Medical School
University of Missouri
University of Texas-MD Anderson Cancer Center
University Physicians Inc.
VCUHS
VHHA

Visiting Nurse Service of New York
VNAA
Wake County Human Services
Washington University in St. Louis
WellCare Health Plans, Inc.
Wisconsin Collaborative for Healthcare Quality
Wisconsin Primary Health Care Association
Yale-New Haven Hospital

AMERICA'S ESSENTIAL HOSPITALS

DATE June 16, 204
TO Board of Directors
FROM Rhonda Gold, CFO
RE Investment Policy Statement

MEMORANDUM

The following action item is requested from the board:

- approve the proposed Investment Policy Statement as presented by Raffa Wealth Management

America's Essential Hospitals recently submitted a request for proposals for a new investment adviser. The investment, audit, and compliance committee selected Raffa Wealth Management, LLC (RWM), a Registered Investment Advisor specializing in investment advisory services for nonprofit organizations. As part of its investment review process, RWM reviewed the organization's financial documents (financial statements, budgets, cash flow projections) and interviewed key personnel to better understand the association's operations, financial outlook, historical investing strategy, and segmentation of reserves. In addition, RWM conducted a risk tolerance survey with the association and Institute board chairs; key association personnel; the investment, audit, and compliance committee; and finance committee to gain consensus on the objective, time frame, and tolerance for volatility of the reserves.

This data was used to develop the attached Investment Policy Statement (IPS) which helped form RWM's formal investment recommendations. The investment, audit, and compliance and finance committees have reviewed the proposed IPS and recommend the board's approval. Mark Murphy, senior portfolio manager, will present the survey findings and proposed IPS, and address your questions, in San Antonio.

Notable changes from the current IPS are:

Rebalancing (page 5): Language was changed from rebalancing the portfolio for changes more or less than 5 percent of the specified target to rebalancing the portfolio if the target allocation moves outside the target range. Language was also added to state that other events may trigger a rebalance, including large deposits or withdrawals and significant market movements.

Delegation and responsibilities (page 6): Language was added to detail the responsibilities of a designated investment adviser (RWM) who will have the responsibility for implementing the investment strategy as outlined in the IPS.

Investment manager reporting and evaluation (page 6): Language was added to state that "investment reports will include benchmarking comparative returns for the portfolio against the performance of each underlying fund or separately managed account in the portfolio against a style- and size-specific benchmark, and will include the current portfolio allocation compared to the target asset allocation."

Definition of allowable investments (page 8): Language was added to define short-term fixed income as fixed income with a maturity of five years or shorter. Intermediate-term fixed income is defined as fixed income with a maturity between 5 and 10 years.

Diversification (page 9): Language was added to state that "no more than 5 percent of the portfolio combined may be in the securities of any one issuer, with the exception of obligations of the U.S. Government and its agencies, and federally insured instruments; and no more than 20 percent of the portfolio combined may be in the securities of a particular industry."

Investment strategies and guidelines (page 9-10):

- Operating account investment strategies and guidelines (page 9): Language was added to define the cash flow expectations for the short-term funding reserve. The new language states that "the operating fund portfolio will provide 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."

  The minimum, target, and maximum allocations for the operating fund were changed as follows:

	Min	Target	Max
Cash Equivalents:			
Current IPS	0%	10%	50%
Proposed IPS	0%	2%	5%
Short-Term Taxable Fixed Income:			
Current IPS	50%	70%	100%
Proposed IPS	52%	65%	78%
Intermediate Taxable Fixed Income:			
Current IPS	0%	20%	50%
Proposed IPS	24%	30%	36%

Language was added to state that the operating fund will target a weighted average maturity of three years or less and a weighted average credit quality of no lower than AA. Benchmarking language was added to state that "the portfolio will be compared to a benchmark comprising 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."

- The intermediate account was deleted.

- Long-term reserve fund investment strategies and guidelines (page 10): Language was added to state that "this portfolio is not expected to be a direct source of cash flow for America's Essential Hospitals." The fixed income asset class will target a weighted average maturity of eight 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 language was added to state that "the portfolio will be compared to a benchmark comprising 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."

  Large-cap, mid–cap, and small-cap equity funds were deleted and replaced with one category, "U.S. equities"; fixed income funds were added. The minimum, target, and maximum allocations for the long-term reserve fund in the new IPS are proposed to be these:

	Min	Target	Max
Cash Equivalents	0%	1%	2%
US Equities	29%	36%	43%
International Equities	15%	19%	23%
Fixed Income	36%	45%	54%

We will review these materials with you at the June board meeting, but should you have any questions before then, please contact Rhonda at 202-585-0109 or rgold@essentialhospitals.org.

Attachments:
Proposed Investment Policy Statement

Statement of Investment Policy

essentialhospitals.org

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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 care 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, and compliance committee (the "IAC") 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 IAC herein. Otherwise, the IAC shall implement the management process and monitor the fund in accordance with this statement.

The IAC, 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 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, 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.

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

This statement shall be reviewed annually by the IAC 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 advisers.

Reports on the fund shall be provided at least three times per year to the IAC. 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.

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. These are the primary investment objectives of the fund:

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 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 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 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 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 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 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 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 separately.

Standard of conduct: In managing and investing the fund, the IAC 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 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 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 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 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 United States 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 five 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 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 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 percent of the portfolio combined may be in the securities of any one issuer with the exception of obligations of the U.S. Government and its agencies, and federally insured instruments. (2) No more than 20 percent 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

	Minimum	Target	Maximum
Cash Equivalents	0%	2%	5%
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 three years or less and a weighted average credit quality of no lower than AA.

Benchmarking: The portfolio will be compared to a benchmark comprising 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 America's Essential Hospitals.

Target Allocations

	Minimum	Target	Maximum
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 eight 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 comprising 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.