



AMERICA'S
ESSENTIAL
HOSPITALS

Board of Directors Meeting

June 23, 2015
The Westin Gaslamp
San Diego, CA

essentialhospitals.org

AMERICA'S ESSENTIAL HOSPITALS
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AMERICA'S ESSENTIAL HOSPITALS

Association Board of Directors Meeting June 23, 2015 11 am - 5 pm ET Agenda

11 – 11:05 am	Call to Order and Disclose Conflicts of Interest (Walker)	
11:05 – 11:10 am	Welcome New Board Members (Walker)	
11:10 – 11:15 am	Approve Consent Agenda (Walker)	ACTION
	• March minutes	
	• New members	
11:15 – 11:30 am	President's Report (Siegel)	
11:30 – 11:45 am	Treasurer's Report (Coopwood)	ACTION
11:45 am – 12:15 pm	Member Engagement Index (Metter)	
12:15 – 12:45 pm	Lunch	
12:45 – 2:00 pm	Committee Reports:	ACTION
	• Membership Committee (Hammack)	
	• Education Committee (Belzer)	
	• Policy Advisory Committee (Haupert)	ACTION
2 – 2:15 pm	Break	
2:15 – 3:30 pm	Policy/Advocacy Update (Gremminger)	
3:30 – 4:15 pm	Institute Report (Engler)	
4:15 – 4:45 pm	Executive Session	
4:45 – 5 pm	Board Photo	
5 pm	Adjourn	



AMERICA'S ESSENTIAL HOSPITALS

America's Essential Hospitals Board of Directors

2014–2015

CHAIR

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

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

CHAIR-ELECT

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

Wright Lassiter III (2014–2015)
President
Henry Ford Health System

PAST-CHAIR

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

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

SECRETARY

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

Sharon O'Keefe (2014–2016)
President
University of Chicago Medicine

TREASURER

Reginald W. Coopwood, MD
President and CEO
Region One Health

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

AT-LARGE DIRECTORS

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

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

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

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

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

EX OFFICIO
Irene M. Thompson
Vice Chair
UHC AMC Affinity Company Board of Managers



America's Essential Hospitals Board of Directors 2015–2016

CHAIR

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

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

CHAIR-ELECT

John M. Haupert
President and CEO
Grady Memorial Hospital

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

PAST-CHAIR

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

Carlos A. Migoya (2015–2017)
President and CEO
Jackson Health System

SECRETARY

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

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

TREASURER

Roxane A. Townsend, MD
Vice Chancellor for Clinical Programs, CEO
University Medical Center UAMS
University of Arkansas for Medical Sciences

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

AT-LARGE DIRECTORS

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

Samuel L. Ross, MD, MS (2015–2017)
CEO
Bon Secours Hospital

Akram Boutros, MD (2015–2017)

President and CEO
The MetroHealth System

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

Timothy M. Goldfarb (2014–2016)

EVP, for Regional & Governmental Affairs
UF Health Shands Hospital

EX OFFICIO
Irene M. Thompson
Vice Chair
UHC AMC Affinity Company Board of Managers

Stan Hammack (2015–2017)

CEO
University of South Alabama Medical Center



AMERICA'S
ESSENTIAL
HOSPITALS

2014 – 2015 Board of Directors Participation Grid

Member	Organization	6/24/14	10/28/14	12/1/14 Call	3/16/15
Michael Belzer	Hennepin County Medical Center	X	X		X
Reginald Coopwood	Region One Health	X	X	X	X
Timothy Goldfarb	UF Shands HealthCare		*X	X	
John Haupert	Grady Health System	X		X	
George Hernandez	University Health System	X	*X	X	
Michael Karpf	UK Health Care	X	X	X	X
Wright Lassiter	Henry Ford Health System		X	X	X
Santiago Muñoz	UCLA Health System	X	*X		
Sharon O'Keefe	University of Chicago Medicine	N/A	N/A	X	X
Ramanathan Raju	New York City Health and Hospitals Corp	X		X	X
Donna Sollenberger	The University of Texas Health System	X	*X	X	
Johnese Spisso	UW Medicine		X		X
Irene Thompson	UHC	X			X
Roxane Townsend	University of Arkansas for Medical Sciences	X	*X	X	X
Thomas Traylor	Boston Medical Center	X	X	X	X
William Walker	Contra Costa Health Services	X	X	X	X

Key:

X: board member was present at meeting

*X: board member participated by phone at an in-person meeting



AMERICA'S ESSENTIAL HOSPITALS

2015 – 2016 America's Essential Hospitals Committees

Awards Committee

FN	LN	Organization	City	ST	Term
Lawrence	Antonucci	Lee Memorial Health System	Fort Myers	FL	Chair, 2014–2016
Aaron	Byzak	UC San Diego	San Diego	CA	2014–2016
Parveen	Chand	Eskanazi health	Indianapolis	IN	2014–2016
Jacey	Cooper	Kern Medical Center	Bakersfield	CA	2014–2016
Timothy	Curtin	Memorial Healthcare System	Hollywood	FL	2015–2017
Barry	Fisher	Ventura County Hospital	Ventura	CA	2015–2017
Cortney	Forward	The Ohio State University Wexner Medical Center	Columbus	OH	2015–2017
Barton	Hill	St. Luke's Health System	Boise	ID	2015–2017
Paul	Keuhnert	Robert Wood Johnson Foundation	Princeton	NJ	2014–2016
Anthony	Patterson	UAB	Birmingham	AL	2015–2017
Rhonda	Scott	Grady Health System	Atlanta	GA	2015–2017
Ron	Wyatt	The Joint Commission	Chicago	IL	2014–2016

Education Committee

FN	LN	Organization	City	ST	Term
Sherrie	Williams	MetroHealth System	Cleveland	OH	Chair, 2015–2016
Michael	Belzer	Hennepin County Medical Center	Minneapolis	MN	Past Chair, 2015–2016
Bob	Brooks	Erlanger	Chattanooga	TN	2015–2016
Craig	Cathcart	Swedish Covenant Hospital	Chicago	IL	2015–2017
Susan	Cooper	Regional One Health	Memphis	TN	2014–2016
Susan	Currin	San Francisco General Hospital and Trauma Center	San Francisco	CA	2014–2016
Delvecchio	Finley	Harbor-UCLA Medical Center	Torrance	CA	2014–2016
James	Gonzalez	University Hospital	Newark	NJ	2014–2016
Doug	Luckett	CaroMont - CEO	Gastonia	NC	2015–2017
Tom	Quatroche	Erie County Medical Center	Buffalo	NY	2015–2017
Steve	Strakowski	UC Health	Cincinnati	OH	2015–2017
Arnold	Tabuenca	Riverside County Regional Medical Center	Moreno Valley	CA	2015–2017
Ron	Wiewora	Palm Beach County	Palm Beach	FL	2015–2017
Joseph	Woelkers	UT Health Northeast	Tyler	TX	2015–2017

Finance Committee

FN	LN	Organization	City	ST	Term
Roxane	Townsend	University of Arkansas for Medical Sciences	Little Rock	AR	Chair, 2015–2016
Michael	Karpf	UK HealthCare	Lexington	KY	2014–2016
Wright	Lassiter	Alameda Health System	Oakland	CA	2015–2017
Carlos	Migoya	Jackson Memorial	Miami	FL	2015–2017
Donna	Sollenberger	University of Texas Medical Branch	Galveston	TX	2014–2016



AMERICA'S ESSENTIAL HOSPITALS

Investment, Audit & Compliance Committee

FN	LN	Organization	City	ST	Term
Gordon	Crabtree	University of Utah Health Care	Salt Lake City	UT	Chair, 2015–2017
Frank	Arambula	Arrowhead Regional Medical Center	Colton	CA	2015–2017
Heidi	Conrad	Regions Hospital	Saint Paul	MN	2015–2017
Susan	Moffatt-Bruce	The Ohio State University Wexner Medical Center	Columbus	OH	ExOff, 2016
Steve	Short	Tampa General Hospital	Tampa	FL	2014–2016
Roxane	Townsend	University of Arkansas for Medical Sciences	Little Rock	AR	ExOff, 2016
Cass	Wisniewski	Hurley Medical Center	Flint	MI	2014–2016

Membership Committee

FN	LN	Organization	City	ST	Term
Stan	Hammack	USA Medical Center (University of South Alabama)	Mobile	AL	Chair, 2014–2016
LaRay	Brown	New York City Health and Hospitals Corporation	New York	NY	2014–2016
Tim	Goldfarb	UF Health Shands	Gainesville	FL	2014–2016
Stephen	McKernan	UNM Hospitals	Albuquerque	NM	2015–2017
Santiago	Muñoz	UCLA Health System	Los Angeles	CA	2014–2016
Jim	Nathan	Lee Memorial Health System	Fort Myers	FL	2015–2017
Sam	Ross	Bon Secours	Baltimore	MD	2015–2017
David	Small	United Medical Center	Washington	DC	2015–2016
Thomas	Traylor	Boston Medical Center	Boston	MA	2014–2016
James	Valenti	University Medical Center of El Paso	El Paso	TX	2015–2017

Medical Leaders Interest Group Steering Committee

FN	LN	Organization	City	ST	Term
Barton	Hill	St. Luke's Health System	Boise	ID	Chair, 2015–2017
Michael	Belzer	Hennepin County Medical Center	Minneapolis	MN	Past Chair, 2016
Abha	Agrawal	Norwegian American	Chicago	IL	2015–2017
Bryan	Alsip	UHS	San Antonio	TX	2015–2016
Krishna	Das	Cook County Health & Hospitals System	Chicago	IL	2015–2016
Peter	DeBlieux	Interim LSU Hospital	New Orleans	LA	2015–2017
Mark	Steele	Truman Medical Center	Kansas City	MO	2015–2016
Arnold	Tabuenca	Riverside County Regional Medical Center	Moreno Valley	CA	2015–2016



AMERICA'S ESSENTIAL HOSPITALS

Policy Advisory Committee

FN	LN	Organization	City	ST	Term
John	Haupert	Grady Health System	Atlanta	GA	Chair, 2014–2016
Akram	Boutros	The MetroHealth System	Cleveland	OH	2015–2017
Kirk	Calhoun	UT Health Northeast	Tyler	TX	2015–2017
Patrick	Cawley	MUSC	Charleston	SC	2015–2016
Susan	Erhlich	San Mateo Medical Center	San Mateo	CA	2014–2016
Jeff	Feasel	Halifax Health	Daytona Beach	FL	2015–2017
Avijit	Ghosh	University of Illinois Hospital Health Sciences	Chicago	IL	2015–2017
Art	Gonzalez	Denver Health	Denver	CO	2015–2016
John	McCabe	SUNY Upstate	Syracuse	NY	2015–2017
Sharon	O'Keefe	University of Chicago	Chicago	IL	2015–2017
David	Pate	St. Luke's Health System	Boise	ID	2014–2016
Steve	Purves	Maricopa Health System	Phoenix	AZ	2015–2017
Joseph	Scott	Liberty Health	Jersey City	NJ	2014–2016
Charles	Shields	Truman Medical Centers	Kansas City	MO	2015–2016
Donna	Sollenberger	UTMB	Galveston	TX	2015–2017
Patrick	Wardell	Cambridge Health Alliance	Cambridge	MA	2014–2016

Strategic Planning Committee

FN	LN	Organization	City	ST	Term
Michael	Karpf	UK HealthCare	Lexington	KY	Chair, 2014–2016
Terry	Andrus	East Alabama Medical Center	Opelika	AL	2015–2016
Dan	Castillo	LAC+USC	Los Angeles	CA	2015–2016
Chris	Colenda	WVU	Morgantown	WV	2015–2016
Reginald	Coopwood	Regional Medical Center at Memphis	Memphis	TN	2015–2017
Eric	Dickson	UMASS Memorial Health Care	Worcester	MA	2014–2016
Barry	Freedman	Einstein Healthcare Network	Philadelphia	PA	2015–2016
Leon	Haley	Grady Health System	Atlanta	GA	2015–2017
George	Hernandez	University Health System	San Antonio	TX	2015–2017
John	Kastanis	Temple University Hospital	Philadelphia	PA	2014–2016
Christine	Neuhoff	St. Luke's Health System	Boise	ID	2015–2017
Jon	Pryor	Hennepin County Medical Center	Minneapolis	MN	2015–2017
Ram	Raju	NYCHHC	New York	NY	2015–2016
Mitch	Wasden	University of Missouri	Columbia	MO	2014–2016



Association Board Meeting Dates

Monday, October 26, 2015

11 am – 5 pm

Hyatt Regency Washington on Capitol Hill
Washington, DC

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

Monday, December 14, 2015

11 am – 12:30 pm ET

Conference call

Monday, March 7, 2016

11 am – 5 pm

America's Essential Hospitals Office
Washington, DC

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

Tuesday, June 14, 2016

11 am – 5 pm

Seaport Hotel
Boston, MA

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

October 2016

America's Essential Hospitals Office
Washington, DC

December 2016 conference call - TBD



Board of Directors Meeting
March 16, 2015
Washington, DC

Board Members Present (11)	Board Members Absent (6)	Staff Present (8)
Michael B. Belzer, MD Reginald W. Coopwood, MD Michael Karpf, MD Wright L. Lassiter III Sharon O'Keefe, MS Ramanathan Raju, MD, MBA Johnese M. Spisso, MPA, RN Irene M. Thompson Roxane A. Townsend, MD Thomas P. Traylor, MBA William B. Walker, MD	John M. Haupert George Hernandez Jr., JD Timothy M. Goldfarb Santiago Muñoz III Sheldon Retchin, MD, MSPH Donna K. Sollenberger, MA	Bruce Siegel, MD, MPH David Engler, PhD Beth Feldpush, DrPH Rhonda Gold Kristine Metter Sarah Callahan, MHSA Caitlyn Furr Carl Graziano

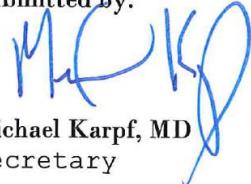
Agenda Item	Minutes
Call to Order and Disclosure of Conflicts of Interest (Walker)	<ul style="list-style-type: none">Walker called the meeting to order at 11:04 am. He asked for conflicts of interest; none were disclosed.
Consent agenda (Walker)	Members reviewed the December 1 meeting minutes. <i>Walker requested a motion to approve the consent agenda. There was a motion, a second, and unanimous approval of the consent agenda.</i>
President's report (Siegel)	<ul style="list-style-type: none">Siegel welcomed board members and thanked them for approving six new members.Siegel updated board members on items including the following:<ul style="list-style-type: none">Retchin left Virginia Commonwealth University Health System to join The Ohio State University Wexner Medical Center. Retchin also was appointed and confirmed to the Medicaid and CHIP Payment and Access Commission (MACPAC).UHC and VHA are merging into one larger organization. Siegel will sit on the board for the new entity's academic affiliate.

	<ul style="list-style-type: none"> ○ The association will be launching a business advisory council for companies joining the new corporate affiliate member category.
Review and Approve Essential Hospitals Institute Board Nominations (Walker)	<ul style="list-style-type: none"> ● Walker presented nominations for the Institute board of directors. Susan Moffatt-Bruce was nominated to serve as treasurer and Sue Currin was nominated as a new member director. <p><i>Walker requested a motion to approve the Institute board nominations. There was a motion, a second, and unanimous approval of the Institute board nominations.</i></p>
Nominating Committee Report (Spisso)	<ul style="list-style-type: none"> ● Spisso presented the nominees for vacancies on the association board. The membership will vote on the nominees in the spring. ● The nominating committee recommended Haupert as chair-elect, and Townsend as treasurer. ● The nominating committee made the following recommendations to fill vacancies in four at-large director positions: <ul style="list-style-type: none"> ○ Akram Boutros, MD, President and CEO, The MetroHealth System ○ Stan Hammack, CEO, University of South Alabama Medical Center ○ Carlos Migoya, President and CEO, Jackson Health System ○ Sam Ross, MD, MS, CEO, Bon Secours Baltimore Health System
Revised UHC Memorandum of Understanding (Siegel)	<ul style="list-style-type: none"> ● Siegel told the board that the association's relationship with UHC is strategically and financially important. ● The association redrafted the memorandum of understanding (MOU) at UHC's request. It does not change the business terms of the relationship, but clarifies the benefits to UHC's membership, and hopefully, will clearly articulate why the business relationship exists. The document has not yet been approved by UHC or VHA; Irene Thompson said she would recommend that it be executed. ● Siegel told the board that he will work hard to keep the association's relationship with the new company strong. However, the association continues to work to decrease its dependence on UHC's contribution. <p><i>Walker requested a motion to approve the draft MOU and allow Siegel to enter into the revised MOU. There was a motion, a second, and unanimous approval of the draft MOU.</i></p>
Board Member Expectations (Walker)	<ul style="list-style-type: none"> ● Board members reviewed the draft board member expectations and agreed that they will help future candidates understand the commitment of being on the board. Siegel said that the association will also formally track meeting attendance in the board books. <p><i>Walker requested a motion to approve the draft board member expectations. There was a motion, a second, and unanimous approval of the draft board member expectations.</i></p>

Member Satisfaction Survey Results (McKinley Advisors)	<ul style="list-style-type: none"> Metter introduced McKinley Advisors, who conducted and analyzed the member survey. The survey's goal was to ensure that the association is aligned with member needs. Nearly 400 members responded to the electronic survey, and more than half of member hospitals participated. This is a typical response rate for this type of survey. McKinley Advisors said that the survey results were positive for the association, with a net promoter score of 21 and 41 percent of respondents saying that membership value is greater than the cost of their dues. McKinley Advisors found that decision makers strongly favor the association, but the sentiment is weaker among non-decision makers. The association needs to look for opportunities to engage members outside of the C-suite. Decision makers most strongly value advocacy, while non-decision makers value the tangible benefits, such as education. The board discussed ways to engage individuals at all levels of member organizations. Board members discussed interest groups that target chief financial officers and nurses. Board members suggested that the association conduct a survey every other year. The 2017 survey will inform the next strategic plan.
Policy/Advocacy Update (Feldpush)	<ul style="list-style-type: none"> Feldpush reviewed the political scene after significant changes from the 2014 elections. Feldpush told the board that there is an effort underway by Congress to pass a permanent repeal of the sustainable growth rate instead of implementing another temporary patch. The board discussed policy threats and opportunities, such as Medicaid disproportionate share hospital (DSH) payments and risk adjustment for sociodemographic status in readmissions. Feldpush reviewed long-term policy priorities including the 340B Drug Pricing Program, Medicare outpatient payments, graduate medical education, Medicare DSH, and the King v. Burwell case. Feldpush told the board that the policy advisory committee will be looking at pricing transparency and will present principles to the board in June.
Education Committee Report (Belzer)	<ul style="list-style-type: none"> Belzer described the education committee's work to solicit and score the VITAL2015 call for proposals. He gave the board an overview of the VITAL2015 agenda. The 2015-2016 Fellows Program has 39 fellows from 21 different organizations, and the program aimed to involve new members.
Strategic Planning Committee Report (Karpf)	<ul style="list-style-type: none"> Karpf gave an overview of the strategic planning committee meeting, which took place in early March. The meeting served as a midterm check-in for the 2013-2018 strategic plan, and committee members addressed three strategic questions focusing on leadership development, accountability, and population health.

	<ul style="list-style-type: none"> The committee agreed that the association is aligning well with the strategic plan and made no changes to the document. Committee members deemed the Fellows Program successful, and supported the new Women's Leadership Academy. Members suggested that the association keep Fellows engaged after they have finished the program. The committee told staff not to add new leadership programs. The committee told staff to be proactive on certain policy issues, but to be careful in terms of policies that tie in accountability. Risk adjustment is especially important as accountability for hospitals increases. The committee discussed population health and said it would be helpful to have a forum for members to discuss their successes and failures. The association can also add value by determining the most effective population health interventions.
Essential Hospitals Institute Update (Engler)	<ul style="list-style-type: none"> Engler discussed the Essential Hospitals Institute's portfolio of work and upcoming challenges. The Institute recently formed two new committees: the research committee and the women's leadership advisory council. The Institute has partnered with organizations to address population health, equity, and delivery system reform. Board members discussed waivers and agreed the association should focus activities in this area. The first Essential Hospitals Engagement Network contract was considered a success. The Institute expects to renew its contract in June. The Institute is launching the 2015 Fellows. It plans to launch the Women's Leadership Academy at the end of 2015.
Office Move Update (Gold)	<ul style="list-style-type: none"> The association signed the lease for 401 9th Street. The business terms are unchanged from what the board approved in October.
Financial Update (Gold)	<ul style="list-style-type: none"> The recent audit came back clean. The association's revenue is higher than anticipated in the budget. The association budgeted a new administrative position, which is reflected in the revised budget. Due to the delay in the Partnership for Patients contract, some webinar expenses have been moved from the Institute to the association budget. The finance committee recommended approval of the budget. <i>Coopwood requested a motion to approve the budget. There was a motion, a second, and unanimous approval of the draft budget.</i>
Adjourn	<ul style="list-style-type: none"> The meeting was adjourned at 4:25 pm.

Submitted by:



Michael Karpf, MD
Secretary



DATE June 12, 2015
TO Board of Directors
FROM Kristine Metter, Vice President of Member Services
RE New Member Applications

MEMORANDUM

The following two health systems have applied for membership with America's Essential Hospitals:

- Banner Health, Tucson, Arizona
- University Health, Shreveport, Louisiana

Banner Health

Kathy Bollinger, President and CEO, Banner - University Medicine

Banner Health and the University of Arizona Health Network merged at the beginning of the year. Three hospitals within Banner Health's University service line would be members of America's Essential Hospitals: Banner University South, Banner University Tucson, and Banner University Phoenix.

Banner – University Statistics

	South	Tucson	Phoenix
Beds	245	479	733
Employees	881	3317	5855
Discharges (Medicare)	33.7%	31.2%	33.3%
Discharges (Medicaid)	27.5%	34.5%	28.0%
Outpatient visits	197,657	463,234	399,804
Total admissions	7,249	23,082	32,104
Births	NA	1,882	5,855

*Source: American Hospital Association 2013 utilization statistics

University Health

Richard Cascio, Interim CEO

University Health is the proud clinical partner of the distinguished LSU Health Shreveport School of Medicine. As an academic hospital, University Health upholds a strong commitment to state-of-the art treatment, clinical research, and community education and prevention programs.

University Health Shreveport is home to state-designated Centers of Excellence including the Feist-Weiller Cancer Center and a Center of Excellence in Arthritis and Rheumatology. The main campus includes an accredited Children's Hospital, a regional Burn Center and a Trauma Center serving communities across North Louisiana, East Texas and Southwest Arkansas.

University Health

Beds	NA
Employees	NA
Discharges (Medicare)	33.3%
Discharges (Medicaid)	26.6%
Outpatient visits	414,751
Total admissions	20,277
Births	3,397

*Source: American Hospital Association 2013 utilization statistics



DATE June 12, 2015
TO Board of Directors
FROM Rhonda Gold, CFO
RE Financial Update

MEMORANDUM

This memorandum summarizes the 2014 audited financial statements, a 2015 financial projection compared with budget, and an office move and investment update. The finance committee has reviewed and accepted the attached materials.

The board is asked to

- accept America's Essential Hospitals' 2014 audited financial statements as recommended by the investment, audit, and compliance (IAC) and finance committees; and
- accept the 2015 budget update.

2014 audit: America's Essential Hospitals

As reflected on the Statements of Financial Position, total assets are \$14.4 million, of which \$12.1 million are in cash and investments and \$5.7 million are in liabilities, mostly due to deferred revenue for 2015 membership dues invoiced and paid in 2014. The significant increase in cash is because of higher dues revenue in 2014 and the reimbursement of intercompany transactions by the Institute.

As reflected in the Statements of Activities and Changes in Net Assets (exhibit B of the audited financial statements), the association ended the year with \$9.16 million in revenue, including \$185,000 in investment income. This was offset by \$7.07 million in expenses, excluding \$263,230 in contributed legal services and \$111,300 in branding costs funded from reserves, leaving a \$1.97 million change in net assets (21 percent profit margin). The association's total net assets are \$8.73 million, of which \$450,000 is in a board-designated operating reserve to fund the organization's future office relocation. This ending net asset balance continues to represent more than one year of association operating expenses in reserve. There were no management letter comments.

2014 audit: Essential Hospitals Institute

For your information, the audited financial statements for Essential Hospitals Institute are included with your materials. This was approved by the IAC committee and the Institute's finance committee. The Institute ended 2014 with total assets of \$8.52 million, of which \$8.08 million were in cash and other current assets and \$1.11 million in liabilities, mostly a result of

reimbursement due to the association for intercompany expenses (“due to America’s Essential Hospitals”), which was paid in January 2015.

As reflected on the Statements of Activities and Changes in Net Assets, the Institute had \$7.55 million in unrestricted revenue (including \$5.49 million from the Centers for Medicare & Medicaid Services (CMS) Partnership for Patients contract for Essential Hospitals Engagement Network (EHEN)), which was offset by \$6.5 million in expenses, leaving a \$1.05 million change in net assets (“operating surplus”). This represents a 14 percent profit margin.

Total net assets are \$7.41 million, of which \$589,000 is temporarily restricted for existing grants, leaving an operational reserve (“unrestricted”) of almost \$6.83 million. The Institute board set aside \$4.2 million in “board designated” net assets, of which \$3.3 million is in a special purpose fund for programs and other activities that further the Institute’s mission; and \$900,000 is reflected in an operating reserve to cover recurring expenses (e.g., salaries and benefits, rent, office, travel, program, and ongoing professional services). The remaining \$2.63 million is undesignated net assets.

Due to delays by CMS in releasing the request for proposals for renewal of hospital engagement networks, including the Institute’s EHEN, this contract may not be funded until the summer. During this transitional period, the Institute’s board of directors approved using part of the net asset balance from prior years’ unspent contract funds to cover the ongoing costs of our performance improvement work.

2015 financial update

The financial projection for the year is reflected in column 3 of Attachment I. Because the board recently approved a revised budget, in March, there are no significant budget variances to report now. Projected revenue and expenses of \$10.26 million and \$9.03 million, respectively, are on target with budget, and the projected change in net assets is \$644,000 (6 percent profit margin after funding of the office move from reserves).

Office move update

The office move budget approved by the board is included in Attachment II. The total budgeted costs, including the office build-out, furniture, audio-visual and other equipment, and branding, is budgeted at \$4.3 million, of which \$2.4 million will be covered by the tenant improvement allowance (at \$115 per square foot), for a total net cost of approximately \$1.9 million. In consultation with our project manager, we are closely monitoring this budget and will provide ongoing updates to the finance committee and board as we progress through the move.

A fully executed lease has been signed and the move is scheduled for December 29, during the week the office is closed for the holidays. Our architects have presented their schematic design for the “look and feel” of the office, the audio-visual plan is complete, furniture vendors have been selected, and the staff design team approved an initial rendering of the office finishes. We received five responses from general contractors to our request for proposals (RFPs) for construction; we are finalizing the selection from a second round of RFPs containing detailed specifications from the architects and project managers. We are continuing our work on incorporating our brand in the new suite, selecting phone and data systems, and reviewing our other equipment needs.

Investment update

The IAC and finance committees reviewed and accepted this investment update. The following summarizes the association's investment portfolio as of April 30.

America's Essential Hospitals' long-term reserve is a balanced portfolio with almost \$2.95 million in assets. The investment strategy has a tilt toward growth, invested 55 percent and 45 percent in stock and bonds, respectively. The portfolio was in line with its target allocations as of April 30. The portfolio gained 2.7 percent, or \$77,000, for the year to date and is up 2.8 percent, or \$81,000, since the portfolio's inception on June 30, 2014. This compares with the portfolio benchmark, which was up 3 percent and 3.9 percent over the year to date and since inception, respectively. The portfolio slightly trailed the benchmark over the year to date, which was a result of Raffa Wealth Management's advisory fees, as all asset allocations were in line or outpaced their benchmark. Since inception, the portfolio trailed the benchmark as a result of weaknesses from the equity allocation, as the tilt toward small cap and value stocks was out of favor over the second half of 2014. The fixed income allocations outpaced their benchmarks, but not by enough to balance the weakness from the equity allocations.

The America's Essential Hospitals' operating reserve of \$2.53 million is invested conservatively, with a 100 percent allocated to fixed income. The portfolio targets a weighted average credit quality of at least AA and weighted average maturity of three years or less. The portfolio was in line with its target allocations as of April 30. The portfolio gained 0.5 percent, or \$14,000, for the year to date and is up 0.8 percent, or \$22,000, since the portfolio's inception on June 30, 2014. This compares with the portfolio benchmark, which was up 0.6 percent and 1.2 percent over the year to date and since inception, respectively. Over the year to date, the portfolio has been in line with the benchmark, and since inception, the portfolio has slightly trailed due to the portfolio transition that took place in July 2014.

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

Attachments:

2015 Financial Projection Compared with Budget (Attachment I)
Office Move Budget (Attachment II)
2014 Audited Financial Statements for America's Essential Hospitals
2014 Audited Financial Statements for Essential Hospitals Institute



ATTACHMENT I
2015 Budget Update

	col 1 2014 Audit	col 2 2015 Budget	col 3 2015 Projection	col 4 Budget change
REVENUE:				
Membership Dues	\$ 5,379,800	\$ 6,612,000	\$ 6,612,000	\$ -
UHC Membership Dues and Sponsorships	\$ 3,150,000	\$ 3,170,000	\$ 3,170,000	\$ -
Other sponsorships	\$ 246,995	\$ 200,000	\$ 200,000	\$ -
Conferences	\$ 172,228	\$ 260,000	\$ 260,000	\$ -
Partnership for Medicaid	\$ 12,872	\$ 20,000	\$ 20,000	\$ -
Publication Sales/Misc.	\$ 17,077	\$ -	\$ -	\$ -
TOTAL REVENUE	\$ 8,978,972	\$ 10,262,000	\$ 10,262,000	\$ -
EXPENSE:				
Personnel Labor & Fringes	\$ 4,096,153	\$ 4,640,000	\$ 4,640,000	\$ -
Policy	\$ 260,432	\$ 294,000	\$ 294,000	\$ -
Advocacy	\$ 430,002	\$ 653,000	\$ 653,000	\$ -
Member Services	\$ 251,549	\$ 244,700	\$ 244,700	\$ -
Partnership for Medicaid	\$ 12,872	\$ 20,000	\$ 20,000	\$ -
Consulting/Prof Fees	\$ 111,049	\$ 117,500	\$ 117,500	\$ -
Retainer	\$ 400,000	\$ 350,000	\$ 350,000	\$ -
Information Technology	\$ 98,118	\$ 111,300	\$ 111,300	\$ -
Rent	\$ 333,023	\$ 385,000	\$ 385,000	\$ -
Office expenses/equipment rental	\$ 157,480	\$ 228,500	\$ 228,500	\$ -
Communications	\$ 247,596	\$ 231,000	\$ 231,000	\$ -
Conferences	\$ 437,190	\$ 637,000	\$ 637,000	\$ -
Travel and Prof Development	\$ 112,670	\$ 180,000	\$ 180,000	\$ -
Taxes, Insurance and Misc.	\$ 72,109	\$ 87,000	\$ 87,000	\$ -
Depreciation/Amortization	\$ 54,340	\$ 157,000	\$ 157,000	\$ -
Project Development	\$ 3,268	\$ 100,000	\$ 100,000	\$ -
Contribution /Support to Institute	\$ -	\$ 595,000	\$ 595,000	\$ -
TOTAL EXPENSE	\$ 7,077,851	\$ 9,031,000	\$ 9,031,000	\$ -
Changes in Net Assets before funding from reserves	\$ 1,901,121	\$ 1,231,000	\$ 1,231,000	\$ -
Other Items funded from Reserves:				
Office move/Rebranding	\$ (111,291)	\$ (587,000)	\$ (587,000)	\$ -
		\$ -	\$ -	\$ -



ATTACHMENT I
2015 Budget Update

	col 1 2014 Audit	col 2 2015 Budget	col 3 2015 Projection	col 4 Budget change
Changes in Net Assets, after funding from reserves (operating surplus) & before non-operating income	\$ 1,789,830	\$ 644,000	\$ 644,000	\$ -
Non-Operating Income:				
Interest/Dividend Income	\$ 75,295	\$ -	\$ -	\$ -
Realized Capital Gains/(Losses)	\$ 558,944	\$ -	\$ -	\$ -
Unrealized Gains/(Losses)	\$ (449,270)	\$ -	\$ -	\$ -
Non-operating (Investment) Income	\$ 184,969	\$ -	\$ -	\$ -
Changes in Net Assets, after Non-Operating Income	\$ 1,974,799	\$ 644,000	\$ 644,000	\$ -
NET ASSETS:				
Prior Year Net Assets	\$ 6,759,350	\$ 8,734,149	\$ 8,734,149	\$ -
Change in Net Assets	\$ 1,974,799	\$ 644,000	\$ 644,000	\$ -
Total Net Assets	\$ 8,734,149	\$ 9,378,149	\$ 9,378,149	\$ -
Contribution to Restricted Net Assets:				
Office Relocation (restricted net assets)	\$ (200,000)	\$ -	\$ -	\$ -
Total Contribution to Restricted Net Assets	\$ (200,000)	\$ -	\$ -	\$ -
Summary of Total Net Assets:				
Unrestricted Net Assets	\$ 8,284,149	\$ 8,928,149	\$ 9,378,149	\$ 450,000
Restricted Net Assets for office relocation	\$ 450,000	\$ 450,000	\$ -	\$ (450,000)
Total Net Assets	\$ 8,734,149	\$ 9,378,149	\$ 9,378,149	\$ -

**America's Essential Hospitals
Project Budget**

4/17/2015

RSF:
21,561

Item	Quantity	Units	Unit Costs	Approved Budget	Current Total	\$/RSF	Comments
Professional Services:							
Architect Design Services	21,561	RSF	3.90	82,040	80,854	3.75	FOX - includes LEED
Visioning Session Meeting 2	1	LS	750	750			Included in Architect Design Services
Change Management - Communication	1	LS	7,000				
Architect Furniture Procurement	21,561	RSF	0.81	17,039	12,000	0.56	FOX- Hrly NTE
Furniture Procurement Consultant	21,561	RSF	1.00	21,036	15,400	0.71	B-More w/ Mark up
Architect Art Selection Assistance	21,561	RSF	0.25	5,259	5,259	0.24	
Architect Branding Services	21,561	RSF	0.65	13,673	14,015	0.65	FOX
MEP Engineering	21,561	RSF	1.13	23,771	23,501	1.09	FOX
MEP Building DD/ Preliminary LEED					3,234	0.15	FOX
MEP LEED	21,561	RSF	0.29	6,100	6,468	0.30	FOX
LEED Commissioning	21,561	RSF	0.33	6,942	6,900	0.32	FOX
Structural Engineer	1	LS	5,000	5,000	5,000	0.23	
Computer Consultant	1	LS	10,000	10,000		0.00	
AV Consultant					11,125	0.52	Tritech Proposal
Signage Coordination	21,561	RSF	0.19	3,997	3,881	0.18	FOX
FOX Services in 2015	21,561	RSF	0.25	5,259	5,259	0.24	FOX
Legal Fees, Lease & GC Agreement	1	LS	40,000	40,000	65,728	3.05	Miles and Stockbridge
Landlord Fee	1	LS	10,000	10,000	10,000	0.46	10k Lumpsum
Design Contingency	1	LS	29,341	29,341	31,353	1.45	15% Contingency
Reimbursable Expenses	1	LS	10,000	10,000	10,000	0.46	Allowance
Architect + MEP for LEED Silver	21,561	RSF	0.45	9,466			
Subtotal: Professional Services, incl LEED silver			13.90	299,674	309,977	14.38	
Permit/Construction:							
Building Permit	1	LS	30,000	30,000	30,000	1.39	
Occupancy Permit Fee	1	LS	1,000	1,000	1,000	0.05	
Permit Expeditor Building Permit	1	LS	1,200	1,200	1,200	0.06	
Permit Expeditor C of O	1	LS	1,000	1,000	1,000	0.05	
Building Engineer	30	HRS	95.00	2,850	2,850	0.13	
Subtotal: Permit/Construction				36,050	36,050	1.67	
Construction:							
General Contractor	21,561	RSF	90.00	1,893,240	1,940,490	90.00	
Subtotal: GC				1,893,240	1,940,490	90.00	
Audiovisual:							
AV Equipment	1	LS	500,000.00	500,000	286,784	13.30	
Subtotal: Audiovisual				500,000	286,784	23.19	
Security:							
Security System	21,561	RSF	1.50	31,554	32,342	1.50	
Subtotal: Security				31,554	32,342	1.46	
Signage:							
Office Signage	21,561	RSF	0.50	10,518	10,781	0.50	
Branding	21,561	RSF	1.50	31,554	32,342	1.50	
Subtotal: Signage				42,072	43,122	2.00	
SUBTOTAL: BUILDOUT COSTS/HARD COST				2,802,590	2,648,764	123	2,648,764
Project Contingency on buildout/hard costs			10%	280,259	413,799	19.19	16%
TOTAL BUILDOUT/HARD COSTS				3,082,849	3,062,563	142.04	
Lease TI Allowance	21,561	RSF	115.00	(2,419,140)	(2,479,515)	(115.00)	
NET BUILDOUT/HARD COSTS, AFTER TI				663,709	583,048	27.04	
NON-BUILDOUT COSTS/Soft Costs as Defined by the Lease							
Telephone Service:							
Handsets/Telephone System	21,561	RSF	4.00	84,144	86,244	4.00	
Voice and Data Cabling	21,561	RSF	2.25	47,331	48,512	2.25	
Internet Services							Separate Budget
Subtotal: Telephone				131,475	134,756	6.25	
Furniture							
Furniture	21,561	RSF	30.00	631,080	646,830	30.00	
Subtotal: Furniture				631,080	646,830	30.00	
Move:							
Move Company	21,561	RSF	1.25	26,295	26,951	1.25	
Move Consultants	21,561	RSF	1.25	26,295	26,951	1.25	
Subtotal: Move				52,590	53,903	2.50	
IT:							
Cable TV				6,000	6,000	0.28	
Phone system move				4,500	4,500	0.21	
ISP circuit				2,000	2,000	0.09	
Cost to move network to rack				5,000	5,000	0.23	
Rack provider				18,400	18,400	0.85	
Rack for suite				1,200	1,200	0.06	
Install wireless network				3,000	3,000	0.14	
Cabling				32,000			
Switches				8,600	8,600	0.40	
Pod phones (new)				3,000	3,000	0.14	
Subtotal: IT				83,700	51,700	2.40	



**America's Essential Hospitals
Project Budget**

4/17/2015

RSF:
21,561

Item	Quantity	Units	Unit Costs	Approved Budget	Current Total	\$/RSF	Comments
Office Equipment:							
Computers/laptops for common areas and conf room				30,000	30,000	1.39	
IPADS				20,000	20,000	0.93	
Servers				15,000	15,000	0.70	
Cloud				20,000	20,000	0.93	
Copy Machine Lease				35,500	35,500	1.65	RG Estimate
Coffee & Vending				24,000	24,000	1.11	RG Estimate
Misc. Kitchen Items				5,000	5,000	0.23	RG Estimate
Subtotal: Office Equipment				149,500	149,500	6.93	Separate Budget (RG guess)
Artwork:							
Artwork				35,000	35,000	1.62	
Subtotal: Artwork				35,000	35,000	1.62	Separate Budget (RG guess)
Stationary:							
Stationary (printing and design for new address)				20,000	20,000	0.93	
Subtotal: Stationary				20,000	20,000	0.93	RG guesstimate
Insurance:							
General Insurance/LOC fees				45,000	45,000	2.09	
Subtotal: General Insurance/LOC fees				45,000	45,000	2.09	RG estimate/onngoing yrly expense
SUBTOTAL: NON-BUILDOUT COSTS				1,148,345	1,136,689	52.72	1,136,689
Project Contingency on non-buildout costs		10%		114,835	134,686	6.25	11.8%
TOTAL NON-BUILDOUT COSTS, after contingency				1,263,180	1,271,374	58.97	
TOTAL PROJECT BUDGET, OUT OF POCKET				1,926,889	1,854,423	86.01	
TOTAL PROJECT BUDGET, before TI allowance				4,346,029	4,333,938	201.01	

GELMAN, ROSENBERG & FREEDMAN

CERTIFIED PUBLIC ACCOUNTANTS



May 13, 2015

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

We have audited the financial statements of America's Essential Hospitals for the year ended December 31, 2014, and have issued our report thereon dated May 13, 2015. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you dated November 21, 2014.

Professional standards also require that we communicate to you the following information related to our audit.

- **Qualitative Aspects of Accounting Practices**

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by America's Essential Hospitals are described in Note 1 to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during the year ended December 31, 2014. We noted no transactions entered into by America's Essential Hospitals during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected.

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

The most sensitive estimate affecting the financial statements was management's estimate of the allocation of expenses to programs, which is based on an allocation of the actual time spent on each program. We evaluated the key factors and assumptions used to develop the allocation in determining that it is reasonable in relation to the financial statements taken as a whole.

The disclosures in the financial statements are neutral, consistent and clear. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users.

- **Difficulties Encountered in Performing the Audit**

There were no difficulties encountered while performing and completing our audit.

- **Discussions Prior to Retention**

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as America's Essential Hospitals' auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

- **Planned Scope and Timing of the Audit**

We performed our audit according to the planned scope and timing previously communicated to you in our engagement letter and our other letter on planning of the engagement dated November 21, 2014.

- **Management Representations**

We have requested certain representations from management that are included in the management representation letter dated May 13, 2015.

- **Corrected and Uncorrected Misstatements**

Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. All other misstatements detected as a result of audit procedures and corrected by management were not material, either individually or in the aggregate, to the financial statements taken as a whole.

- **Disagreements with Management**

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

- **Management Consultations with Other Independent Accountants**

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to America's Essential Hospitals' financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

- **Independence and Non-Audit Services Provided by Audit Firm**

In accordance with professional standards, during the fiscal year and currently, all members of our firm were independent with respect to America's Essential Hospitals.

During the year under audit, we provided corporate tax preparation services (IRS Form 990) and additional tax advice. All other time and expenses incurred by us were in connection with our annual audit.

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



May 13, 2015

FINANCIAL STATEMENTS

AMERICA'S ESSENTIAL HOSPITALS

**FOR THE YEARS ENDED
DECEMBER 31, 2014 AND 2013**

AMERICA'S ESSENTIAL HOSPITALS

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**EXHIBIT C - Statement of Functional Expenses, for the Year Ended December 31,
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**EXHIBIT D - Statement of Functional Expenses, for the Year Ended December 31,
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NOTES TO FINANCIAL STATEMENTS

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, 2014 and 2013, 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.

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, 2014 and 2013, 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.

May 13, 2015

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AMERICA'S ESSENTIAL HOSPITALS

**STATEMENTS OF FINANCIAL POSITION
AS OF DECEMBER 31, 2014 AND 2013**

ASSETS

	2014	2013
CURRENT ASSETS		
Cash and cash equivalents	\$ 6,716,635	\$ 4,852,739
Investments (Notes 2 and 12)	5,388,953	5,203,984
Accounts receivable	199,780	64,982
Due from Essential Hospitals Institute (Note 4)	932,272	55,007
Prepaid expenses	111,888	107,953
Assets held for deferred executive compensation plan, current portion (Notes 5 and 12)	<u>450,785</u>	-
Total current assets	<u>13,800,313</u>	<u>10,284,665</u>
FURNITURE, EQUIPMENT AND LEASEHOLD IMPROVEMENTS		
Furniture and equipment	1,041,096	984,668
Computer equipment	24,154	24,154
Leasehold improvements	<u>331,831</u>	<u>324,089</u>
Less: Accumulated depreciation and amortization	<u>(1,207,027)</u>	<u>(1,041,510)</u>
Net furniture, equipment and leasehold improvements	<u>190,054</u>	<u>291,401</u>
OTHER ASSETS		
Assets held for deferred executive compensation plan, net of current portion (Notes 5 and 12)	465,285	866,248
Deposits	<u>20,503</u>	<u>20,503</u>
Total other assets	<u>485,788</u>	<u>886,751</u>
TOTAL ASSETS	\$ 14,476,155	\$ 11,462,817

See accompanying notes to financial statements.

LIABILITIES AND NET ASSETS

	2014	2013
CURRENT LIABILITIES		
Accounts payable	\$ 683,319	\$ 401,872
Accrued expenses	1,005,730	673,056
Deferred revenue:		
Membership dues	2,694,750	2,520,800
Other	3,665	50,330
Deferred executive compensation plan liability, current portion (Note 5)	736,347	-
Deferred rent liability, current portion (Note 7)	51,195	43,626
Post-retirement medical plan annuity, current portion (Notes 3 and 12)	<u>3,591</u>	<u>3,447</u>
Total current liabilities	<u>5,178,597</u>	<u>3,693,131</u>
LONG-TERM LIABILITIES		
Deferred executive compensation plan liability, net of current portion (Note 5)	474,108	866,248
Deferred rent liability, net of current portion (Note 7)	-	51,195
Post-retirement medical plan annuity, net of current portion (Notes 3 and 12)	<u>89,299</u>	<u>92,890</u>
Total long-term liabilities	<u>563,407</u>	<u>1,010,333</u>
Total liabilities	<u>5,742,004</u>	<u>4,703,464</u>
NET ASSETS		
Unrestricted	8,284,151	6,509,353
Designated operating reserve (Note 8)	<u>450,000</u>	<u>250,000</u>
Total net assets	<u>8,734,151</u>	<u>6,759,353</u>
TOTAL LIABILITIES AND NET ASSETS	<u>\$ 14,476,155</u>	<u>\$ 11,462,817</u>

See accompanying notes to financial statements.

AMERICA'S ESSENTIAL HOSPITALS

STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS
FOR THE YEARS ENDED DECEMBER 31, 2014 AND 2013

	<u>Unrestricted</u>	
	2014	2013
REVENUE AND SUPPORT		
Dues	\$ 8,371,800	\$ 7,458,783
Sponsorship income	404,995	454,495
Conference and tuition income	172,228	112,235
Investment income (Note 2)	184,968	395,462
Government Relation Academy	-	44,000
Royalty income	-	5,402
Miscellaneous	<u>29,948</u>	<u>-</u>
Subtotal before contributed services and materials	9,163,939	8,470,377
Contributed services and materials (Note 10)	<u>263,230</u>	<u>329,273</u>
Total revenue and support	<u>9,427,169</u>	<u>8,799,650</u>
EXPENSES		
Program Services:		
Member Services and Communications	3,180,348	2,806,868
Lobbying and Advocacy	1,529,670	1,376,832
Policy	<u>1,236,748</u>	<u>1,070,661</u>
Total program services	5,946,766	5,254,361
General and Administrative	<u>1,131,084</u>	<u>1,030,712</u>
Total program and general and administrative before allocation of contributed legal services	7,077,850	6,285,073
Contributed legal services (Note 10)	<u>263,230</u>	<u>329,273</u>
Total expenses including contributed legal services	<u>7,341,080</u>	<u>6,614,346</u>
Changes in net assets before other items	2,086,089	2,185,304
OTHER ITEMS		
Costs funded from reserves (Note 6)	111,291	-
Contribution to Essential Hospitals Institute (Note 4)	<u>-</u>	<u>700,000</u>
Changes in unrestricted net assets	1,974,798	1,485,304
Unrestricted net assets at beginning of year	<u>6,759,353</u>	<u>5,274,049</u>
UNRESTRICTED NET ASSETS AT END OF YEAR	\$ 8,734,151	\$ 6,759,353

See accompanying notes to financial statements.

AMERICA'S ESSENTIAL HOSPITALS
STATEMENT OF FUNCTIONAL EXPENSES
FOR THE YEAR ENDED DECEMBER 31, 2014

	Program Services			Total Program Services	General and Administrative	Total Expenses
	Member Services and Communications	Lobbying and Advocacy	Policy			
Salaries, taxes and benefits (Notes 3 and 5)	\$ 1,667,885	\$ 809,254	\$ 553,357	\$ 3,030,496	\$ 1,065,657	\$ 4,096,153
Professional fees	175,343	276,549	244,574	696,466	85,695	782,161
Auditing fees	10,324	5,009	3,425	18,758	6,596	25,354
Depreciation and amortization	29,481	14,304	9,781	53,566	18,836	72,402
Donations and sponsorships	141,546	-	-	141,546	-	141,546
Legal	80,000	40,000	260,000	380,000	20,000	400,000
Meetings and travel	411,309	128,089	13,957	553,355	81,202	634,557
Equipment rental	20,535	9,963	6,813	37,311	13,120	50,431
Office services	106,533	55,220	16,936	178,689	25,197	203,886
Miscellaneous	17,684	8,580	5,867	32,131	11,299	43,430
Printing, design and layout	77,080	4,971	-	82,051	6,149	88,200
Advertising and media	76,322	-	-	76,322	-	76,322
Rent (Note 6)	135,602	65,794	44,989	246,385	86,638	333,023
Insurance, filing fees and taxes	13,187	6,398	4,883	24,468	8,426	32,894
IT/computer expenses	39,697	19,261	13,170	72,128	25,363	97,491
Sub-total	3,002,528	1,443,392	1,177,752	5,623,672	1,454,178	7,077,850
Allocation of overhead	177,820	86,278	58,996	323,094	(323,094)	-
Sub-total	3,180,348	1,529,670	1,236,748	5,946,766	1,131,084	7,077,850
Contributed legal services (Note 10)	52,646	26,323	171,100	250,069	13,161	263,230
TOTAL	\$ 3,232,994	\$ 1,555,993	\$ 1,407,848	\$ 6,196,835	\$ 1,144,245	\$ 7,341,080

AMERICA'S ESSENTIAL HOSPITALS
STATEMENT OF FUNCTIONAL EXPENSES
FOR THE YEAR ENDED DECEMBER 31, 2013

	Program Services			Total Program Services	General and Administrative	Total Expenses
	Member Services and Communications	Lobbying and Advocacy	Policy			
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	260,000	380,000	20,001	400,001
Meetings and travel	427,089	125,614	8,462	561,165	96,355	657,520
Equipment rental	16,346	8,030	5,590	29,966	13,060	43,026
Office services	74,705	54,760	15,257	144,722	29,042	173,764
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	2,538,863	1,245,182	979,006	4,763,051	1,522,022	6,285,073
Allocation of overhead	268,005	131,650	91,655	491,310	(491,310)	-
Sub-total	2,806,868	1,376,832	1,070,661	5,254,361	1,030,712	6,285,073
Contributed legal services (Note 10)	65,856	32,927	197,563	296,346	32,927	329,273
TOTAL	\$ 2,872,724	\$ 1,409,759	\$ 1,268,224	\$ 5,550,707	\$ 1,063,639	\$ 6,614,346

AMERICA'S ESSENTIAL HOSPITALS
STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2014 AND 2013

	2014	2013
CASH FLOWS FROM OPERATING ACTIVITIES		
Changes in net assets	\$ 1,974,798	\$ 1,485,304
Adjustments to reconcile changes in net assets to net cash provided by operating activities:		
Depreciation and amortization	165,517	147,254
Realized gain on sale of investments	(552,944)	(53,425)
Unrealized loss (gain) on investments	443,271	(194,964)
(Increase) decrease in:		
Accounts receivable	(134,798)	828,643
Due from Essential Hospitals Institute	(877,265)	1,333,234
Prepaid expenses	(3,935)	(16,234)
Assets held for deferred executive compensation plan	(49,822)	(209,941)
Increase (decrease) in:		
Accounts payable	281,442	(158,546)
Accrued expenses	332,674	305,793
Deferred membership dues	173,950	536,225
Other deferred revenue	(46,665)	46,150
Deferred rent liability	(43,626)	(36,211)
Post-retirement medical plan annuity	(3,447)	(2,074)
Deferred executive compensation plan liability	<u>344,207</u>	<u>209,941</u>
Net cash provided by operating activities	<u>2,003,357</u>	<u>4,221,149</u>
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of furniture, equipment and leasehold improvements	(64,170)	(300,012)
Purchases of investments	(10,651,996)	(1,617,504)
Proceeds from sale of investments	<u>10,576,705</u>	<u>1,470,431</u>
Net cash used by investing activities	<u>(139,461)</u>	<u>(447,085)</u>
Net increase in cash and cash equivalents	1,863,896	3,774,064
Cash and cash equivalents at beginning of year	<u>4,852,739</u>	<u>1,078,675</u>
CASH AND CASH EQUIVALENTS AT END OF YEAR	\$ 6,716,635	\$ 4,852,739

See accompanying notes to financial statements.

AMERICA'S ESSENTIAL HOSPITALS

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

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 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 \$135,659 and \$18,404 for the years ended December 31, 2014 and 2013, 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. The cost of maintenance and repairs is recorded as expenses as incurred.

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.

AMERICA'S ESSENTIAL HOSPITALS

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES (Continued)

Sponsorship, conference and tuition income -

America's Essential Hospitals recognized sponsorship and conference revenues when the related event has occurred. Tuition income is recognized as the fees are earned.

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, 2014 and 2013, 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.

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.

AMERICA'S ESSENTIAL HOSPITALS

**NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013**

1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES (Continued)

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, 2014 and 2013 consisted of the following:

	2014	2013
	Fair Value	Fair Value
Money market funds	\$ 135,659	\$ 18,404
Certificate of deposit	-	1,079,565
Exchange traded funds	1,782,527	712,581
Mutual funds:		
Bond funds	2,144,121	3,393,434
Equity funds	<u>1,326,646</u>	-
TOTAL INVESTMENTS	\$ 5,388,953	\$ 5,203,984

Investment income consisted of the following:

	2014	2013
Interest and dividends	\$ 111,597	\$ 183,668
Realized gain	552,944	53,425
Unrealized (loss) gain	(443,271)	194,964
Investment expenses	<u>(36,302)</u>	<u>(36,595)</u>
TOTAL INVESTMENT INCOME	\$ 184,968	\$ 395,462

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, 2014 and 2013 totaled \$7,831 and \$5,640, respectively.

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

<u>Year Ending December 31</u>	
2015	\$ 3,590
2016	3,739
2017	3,896
2018	4,058
2019	4,227
Thereafter	<u>73,380</u>
	\$ 92,890

AMERICA'S ESSENTIAL HOSPITALS

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

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 2014 and 2013. During 2014 and 2013, costs allocated to Essential Hospitals Institute were \$3,960,347 and \$3,081,241, respectively, and the amounts paid by Essential Hospitals Institute to America's Essential Hospitals totaled \$3,083,082 and \$3,160,982, respectively. The 2013 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. There was no such contribution for the year ended December 31, 2014.

At December 31, 2014 and 2013, Essential Hospitals Institute owed \$932,272 and \$55,007, 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 2014 and 2013 totaled \$511,000 and \$417,200, 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, \$254,408 and \$211,523, respectively, were allocated to Essential Hospitals Institute.

Additionally, America's Essential Hospitals maintains an IRC Section 457(b) plan for the President and CEO. Under this plan, participating employees can elect to defer their compensation within IRC guidelines. At December 31, 2014 and 2013, \$241,502 and \$461,757, 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.

During 2002, the Board of Directors authorized an executive compensation plan for all senior level employees. Total contributions to the plan in 2014 totaled \$125,962, \$107,476 of which was allocated to America's Essential Hospitals and \$18,486 of which was allocated to Essential Hospitals Institute. Total contributions to the plan in 2013 totaled \$95,690, \$69,299 of which was allocated to America's Essential Hospitals and \$26,391 of which was allocated to Essential Hospitals Institute (see related party Note 4). At December 31, 2014 and 2013, \$450,785 and \$295,935, respectively, are included in the assets held and deferred liability for the executive compensation plan accounts on the accompanying Statements of Financial Position. Subsequent to year end, the Board of Directors voted to terminate the executive compensation plan and distribute the assets in 2015. The distribution made will also include a partial gross-up amount to cover estimated taxes owed by the participants on the distribution. A total of \$294,385 is included in the deferred liability to accrue for the gross-up amount.

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.

AMERICA'S ESSENTIAL HOSPITALS

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

5. RETIREMENT PLANS (Continued)

Total contributions to this 457(f) plan for the years ended December 31, 2014 and 2013 were \$65,000 and \$53,150, respectively. At December 31, 2014 and 2013, the balance of \$223,783 and \$108,556, respectively, is included in the assets held and deferred liability for the executive compensation plan accounts on the accompanying Statements of Financial Position.

6. COSTS FUNDED FROM RESERVES

During the year ended December 31, 2014, the Board of Directors agreed to fund certain costs related to the office move and the rebranding of America's Essential Hospitals from the Designated Operating Reserve as follows:

Office relation	\$ 18,177
Depreciation on website	<u>93,114</u>
TOTAL COSTS FUNDED FROM RESERVES	\$ <u>111,291</u>

These costs are presented as an Other Item on the accompanying Statements of Activities and Changes in Net Assets.

7. 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, 2014.

On March 4, 2015, America's Essential Hospitals entered into a fifteen-year agreement to lease new office space. Base rent is \$1,449,977, increasing by a factor of 2.5% per year. The lease includes fourteen months of abated rent in the first two years of the lease.

Subsequent to December 31, 2014, America's Essential Hospitals obtained a restricted letter of credit with Bank of America totaling \$471,557. The terms under the new lease to begin January 1, 2016 stipulate that America's Essential Hospitals maintain this letter of credit in lieu of a security deposit.

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. As of December 31, 2014 and 2013, the total deferred rent liability aggregated \$51,195 and \$94,821, respectively.

AMERICA'S ESSENTIAL HOSPITALS

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

7. LEASE COMMITMENT (Continued)

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

<u>Year Ending December 31,</u>	
2015	\$ 738,026
2016	-
2017	1,238,522
2018	1,523,382
2019	1,561,467
Thereafter	<u>19,979,832</u>
	 <u>\$ 25,041,229</u>

The amount of rent allocated to Essential Hospitals Institute at December 31, 2014 and 2013 totaled \$312,033 and \$316,089, respectively. The amount of rent expense for America's Essential Hospitals at December 31, 2014 and 2013 totaled \$333,023 and \$333,816, respectively.

8. DESIGNATED OPERATING RESERVE

At December 31, 2014 and 2013, \$450,000 and \$250,000, respectively of general operating net assets were segregated as a Board designated operating reserve to fund the future office relocation.

9. 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, 2014 and 2013, there were no borrowings on the line of credit.

10. CONTRIBUTED SERVICES AND MATERIALS

In-kind contributions are recorded as revenue at their fair value when received. America's Essential Hospitals recognized \$263,230 and \$329,273 in donated legal services during the years ended December 31, 2014 and 2013, respectively.

11. 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 2017. 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.

AMERICA'S ESSENTIAL HOSPITALS

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013

12. 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.

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. These are investments where 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, 2014 and 2013.

- *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.
- *Exchange traded funds* - Valued at the closing price reported on the active market in which the individual securities are traded (typically tracks an index)
- *Bond and equity funds* - 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, 2014:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Asset Class:				
Money market funds	\$ 135,659	\$ -	\$ -	\$ 135,659
Exchange traded funds	1,782,527	-	-	1,782,527
Bond funds	2,144,121	-	-	2,144,121
Equity funds	<u>1,326,646</u>	<u>-</u>	<u>-</u>	<u>1,326,646</u>
Total investments	<u>5,388,953</u>	<u>-</u>	<u>-</u>	<u>5,388,953</u>
Deferred executive compensation investments	916,070	-	-	916,070
TOTAL ASSETS	<u>\$ 6,305,023</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 6,305,023</u>
Liability Class:				
Deferred executive compensation liability	\$ (916,070)	\$ -	\$ -	\$ (916,070)
Post-retirement medical plan annuity	-	-	(92,890)	(92,890)
TOTAL LIABILITIES	<u>\$ (916,070)</u>	<u>\$ -</u>	<u>\$ (92,890)</u>	<u>\$ (1,008,960)</u>

AMERICA'S ESSENTIAL HOSPITALS

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013

12. FAIR VALUE MEASUREMENT (Continued)

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

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Asset Class:				
Money market funds	\$ 18,404	\$ -	\$ -	\$ 18,404
Certificate of deposit	-	1,079,565	-	1,079,565
Exchange traded funds	712,581	-	-	712,581
Bond funds	<u>3,393,434</u>	<u>-</u>	<u>-</u>	<u>3,393,434</u>
Total investments	<u>4,124,419</u>	<u>1,079,565</u>	<u>-</u>	<u>5,203,984</u>
Deferred executive compensation investments	<u>866,248</u>	<u>-</u>	<u>-</u>	<u>866,248</u>
TOTAL ASSETS	<u>\$ 4,990,667</u>	<u>\$ 1,079,565</u>	<u>\$ -</u>	<u>\$ 6,070,232</u>
Liability Class:				
Deferred executive compensation liability	\$ (866,248)	\$ -	\$ -	\$ (866,248)
Post-retirement medical plan annuity	<u>-</u>	<u>-</u>	<u>(96,337)</u>	<u>(96,337)</u>
TOTAL LIABILITIES	<u>\$ (866,248)</u>	<u>\$ -</u>	<u>\$ (96,337)</u>	<u>\$ (962,585)</u>

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, 2014 and 2013:

	<u>Post-Retirement Medical Plan Annuity</u>
Beginning balance as of January 1, 2013	\$ 98,411
Net periodic costs	(5,640)
Net change in value	<u>3,566</u>
Balance as of December 31, 2013	96,337
Net periodic costs	(7,831)
Net change in value	<u>4,384</u>
BALANCE AS OF DECEMBER 30, 2014	<u>\$ 92,890</u>

13. SUBSEQUENT EVENTS

In preparing these financial statements, America's Essential Hospitals has evaluated events and transactions for potential recognition or disclosure through May 13, 2015, the date the financial statements were issued.

GELMAN, ROSENBERG & FREEDMAN

CERTIFIED PUBLIC ACCOUNTANTS



May 13, 2015

To the Board of Directors
Essential Hospitals Institute
Washington, D.C.

We have audited the financial statements of Essential Hospitals Institute for the year ended December 31, 2014, and have issued our report thereon dated May 13, 2015. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you dated November 21, 2014.

Professional standards also require that we communicate to you the following information related to our audit.

- **Qualitative Aspects of Accounting Practices**

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by Essential Hospitals Institute are described in Note 1 to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during the year ended December 31, 2014. We noted no transactions entered into by Essential Hospitals Institute during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected.

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The most sensitive estimate affecting the financial statements was management's estimate of the allocation of expenses to programs and to Essential Hospitals Institute's related entity, which is based on an allocation of the actual time spent on each program. We evaluated the key factors and assumptions used to develop the allocation in determining that it is reasonable in relation to the financial statements taken as a whole.

The disclosures in the financial statements are neutral, consistent and clear. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users.

The most sensitive disclosure affecting the financial statements was the disclosure of related party transactions in Note 6 to the financial statements.

- **Difficulties Encountered in Performing the Audit**

We encountered no significant difficulties in dealing with management in performing and completing our audit.

- **Corrected and Uncorrected Misstatements**

Professional standards require us to accumulate all misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. In addition, none of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to the financial statements taken as a whole.

We proposed five adjusting journal entries that decreased the net assets by approximately \$1,320. The most significant of these was to reverse an accrual related to 2015 expenses.

- **Disagreements with Management**

For purposes of this letter, a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

- **Planned Scope and Timing of the Audit**

We performed our audit according to the planned scope and timing previously communicated to you in our engagement letter and our other letter on planning of the engagement dated November 21, 2014.

- **Management Representations**

We have requested certain representations from management that are included in the management representation letter dated May 13, 2015.

- **Management Consultations with Other Independent Accountants**

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to Essential Hospitals Institute's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

- **Other Audit Findings or Issues**

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as Essential Hospitals Institute's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

- **Independence and Non-Audit Services Provided by Audit Firm**

In accordance with professional standards, during the fiscal year and currently, all members of our firm were independent with respect to Essential Hospitals Institute.

During the year under audit, we provided corporate tax preparation services (IRS Form 990) and additional tax advice. All other time and expenses incurred by us were in connection with our annual audit.

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



May 13, 2015

GELMAN, ROSENBERG & FREEDMAN

CERTIFIED PUBLIC ACCOUNTANTS



To the Board of Directors
Essential Hospitals Institute
Washington, D.C.

In planning and performing our audit of the financial statements of Essential Hospitals Institute as of and for the year ended December 31, 2014, in accordance with auditing standards generally accepted in the United States of America, we considered Essential Hospitals Institute's internal control over financial reporting (internal control) as a basis for designing our auditing procedures, for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Essential Hospitals Institute's internal control. Accordingly, we do not express an opinion on the effectiveness of Essential Hospitals Institutes internal control.

Our consideration of Essential Hospitals Institute's internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in Essential Hospitals Institute's internal control that might be significant deficiencies or material weaknesses and therefore, there can be no assurance that all such deficiencies have been identified. However, as discussed below, we identified certain matters involving the internal control and other operational matters that are presented for your consideration. This letter does not affect our report dated May 13, 2015 on the financial statements of Essential Hospitals Institute. We will review the status of these comments during our next audit engagement. Our comments and recommendations, all of which have been discussed with appropriate members of management, are intended to improve the internal control or result in other operating efficiencies. We will be pleased to discuss these comments in further detail at your convenience, perform any additional study of these matters, or assist you in implementing the recommendations. Our comments are summarized as follows:

OTHER RECOMMENDATIONS

Fixed Price Contract

Prior Year Comment: At our recommendation, Essential Hospitals Institute did receive written notification that the Federal government was aware of the change in scope of work from the budget estimate of 66 hospitals to the final 30 participating hospitals. The fixed price contract with the government ended in December 2013. As a result of the reduction in scope, Essential Hospitals Institute has recognized a profit on this contract. An audit entry of approximately \$4,300,000 was posted to recognize the deferred revenue/profit from this contract. While the government approved the change in scope, we want to alert management that the Federal government still has the right to come back and request certain funds be reimbursed to them if they would deem this unreasonable.

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Current Year Status: The contract was extended for an additional one year option for a price of approximately \$5.5 million. The grant work was completed with no outstanding receivable or deferred balances, and accordingly, the full amount of the award was recognized to revenue during the year. We continue to note that the government approved the change in scope for work under the original grant and subsequent options.

Timesheet Approvals

Prior Year Status: We noted two (2) of the four (4) randomly selected timesheets lacked supervisory approval. While the controls around the timesheet system appear to be in place, the lack of approvals resulted from transition to the new system. We strongly recommend Essential Hospitals Institute ensure the current procedures are implemented, including an oversight process, with the respect to the approval process with the new electronic timesheet system to ensure all timesheets are adequately approved.

Current Year Status: Employee timesheets are currently being reviewed and approved. We consider this comment adequately addressed.

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



May 13, 2015

FINANCIAL STATEMENTS

ESSENTIAL HOSPITALS INSTITUTE

**FOR THE YEARS ENDED
DECEMBER 31, 2014 AND 2013**

ESSENTIAL HOSPITALS INSTITUTE

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GELMAN, ROSENBERG & FREEDMAN

CERTIFIED PUBLIC ACCOUNTANTS



INDEPENDENT AUDITOR'S REPORT

To the Board of Directors
Essential Hospitals Institute
Washington, D.C.

We have audited the accompanying financial statements of Essential Hospitals Institute, which comprise the statements of financial position as of December 31, 2014 and 2013, 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 of 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.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Essential Hospitals Institute as of December 31, 2014 and 2013, 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.

May 13, 2015

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ESSENTIAL HOSPITALS INSTITUTE
STATEMENTS OF FINANCIAL POSITION
AS OF DECEMBER 31, 2014 AND 2013

	ASSETS	
	2014	2013
CURRENT ASSETS		
Cash and cash equivalents	\$ 4,778,303	\$ 6,844,285
Investments (Notes 2 and 12)	3,304,425	-
Grants receivable, current portion (Note 3)	365,134	1,037,971
Contracts receivable	-	64,740
Prepaid expenses	<u>33,961</u>	<u>34,770</u>
Total current assets	<u>8,481,823</u>	<u>7,981,766</u>
FURNITURE, EQUIPMENT AND LEASEHOLD IMPROVEMENTS		
Furniture and equipment	420,914	437,005
Leasehold improvements (Note 11)	<u>78,839</u>	<u>78,839</u>
	499,753	515,844
Less: Accumulated depreciation and amortization	<u>(453,427)</u>	<u>(402,218)</u>
Net furniture, equipment and leasehold improvements	<u>46,326</u>	<u>113,626</u>
OTHER ASSETS		
Grants receivable, net of current portion (Note 3)	-	363,851
TOTAL ASSETS	\$ 8,528,149	\$ 8,459,243
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts payable	\$ 94,433	\$ 522,332
Accrued salaries and related benefits	44,239	46,674
Current portion of deferred rent abatement (Note 11)	39,349	25,751
Due to America's Essential Hospitals (Note 7)	<u>932,272</u>	<u>55,007</u>
Total current liabilities	<u>1,110,293</u>	<u>649,764</u>
LONG-TERM LIABILITIES		
Deferred rent abatement, net of current portion (Note 11)	-	39,349
Total liabilities	<u>1,110,293</u>	<u>689,113</u>
NET ASSETS		
Unrestricted:		
Undesignated	2,628,038	5,774,070
Board designated (Note 6)	<u>4,200,000</u>	-
Total unrestricted	<u>6,828,038</u>	<u>5,774,070</u>
Temporarily restricted (Note 4)	<u>589,818</u>	<u>1,996,060</u>
Total net assets	<u>7,417,856</u>	<u>7,770,130</u>
TOTAL LIABILITIES AND NET ASSETS	\$ 8,528,149	\$ 8,459,243

See accompanying notes to financial statements.

ESSENTIAL HOSPITALS INSTITUTE
STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS
FOR THE YEARS ENDED DECEMBER 31, 2014 AND 2013

	2014		
	Unrestricted	Temporarily Restricted	Total
REVENUE AND SUPPORT			
Contracts (Notes 9 and 10)	\$ 5,493,808	\$ -	\$ 5,493,808
Grants (Notes 9 and 10)	355,000	-	355,000
Contributions (Note 7)	-	-	-
Tuition income	221,000	-	221,000
Miscellaneous	55,500	-	55,500
Investment income (Note 2)	23,427	-	23,427
Net assets released from donor restrictions (Note 5)	<u>1,406,242</u>	<u>(1,406,242)</u>	<u>-</u>
Total revenue and support	<u>7,554,977</u>	<u>(1,406,242)</u>	<u>6,148,735</u>
EXPENSES			
Grants and Health Care	5,100,544	-	5,100,544
Transformation Center	981,089	-	981,089
Research and Education	403,162	-	403,162
General and Administrative	<u>16,214</u>	<u>-</u>	<u>16,214</u>
Total expenses	<u>6,501,009</u>	<u>-</u>	<u>6,501,009</u>
Changes in net assets	1,053,968	(1,406,242)	(352,274)
Net assets at beginning of year	<u>5,774,070</u>	<u>1,996,060</u>	<u>7,770,130</u>
NET ASSETS AT END OF YEAR	<u>\$ 6,828,038</u>	<u>\$ 589,818</u>	<u>\$ 7,417,856</u>

See accompanying notes to financial statements.

2013		
Unrestricted	Temporarily Restricted	Total
\$ 7,985,704	\$ -	\$ 7,985,704
526,869	1,800,000	2,326,869
700,000	-	700,000
246,000	-	246,000
200		200
9,118	-	9,118
<u>1,295,306</u>	<u>(1,295,306)</u>	<u>-</u>
<u>10,763,197</u>	<u>504,694</u>	<u>11,267,891</u>
4,364,227	-	4,364,227
855,996	-	855,996
414,114	-	414,114
<u>316,781</u>	<u>-</u>	<u>316,781</u>
<u>5,951,118</u>	<u>-</u>	<u>5,951,118</u>
4,812,079	504,694	5,316,773
<u>961,991</u>	<u>1,491,366</u>	<u>2,453,357</u>
\$ 5,774,070	\$ 1,996,060	\$ 7,770,130

See accompanying notes to financial statements.

ESSENTIAL HOSPITALS INSTITUTE
STATEMENT OF FUNCTIONAL EXPENSES
FOR THE YEAR ENDED DECEMBER 31, 2014

	Grants and Health Care	Transformation Center	and Education	General and Administrative	Total Expenses
Salaries and employee benefits (Notes 6 and 7)	\$ 1,944,710	\$ 608,612	\$ 361,329	\$ 731,616	\$ 3,646,267
Equipment	-	-	-	18,002	18,002
Office supplies and services	26,833	9,315	13,865	53,394	103,407
Rent (Note 9)	218,833	-	-	93,200	312,033
Printing	-	-	1,050	174	1,224
Travel and meetings	781,371	142,462	13,346	47,689	984,868
Depreciation and amortization	-	-	-	51,209	51,209
Consultants and sub-contracted services	988,319	149,384	6,677	61,065	1,205,445
IT and computer	111,978	-	-	27,256	139,234
Investment fees	-	-	-	8,562	8,562
Miscellaneous	-	-	6,895	23,863	30,758
Sub-total	4,072,044	909,773	403,162	1,116,030	6,501,009
Allocation of overhead	1,028,500	71,316	-	(1,099,816)	-
TOTAL	\$ 5,100,544	\$ 981,089	\$ 403,162	\$ 16,214	\$ 6,501,009

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

	Grants and Health Care	Transformation Center	Research and Education	General and Administrative	Total Expenses
Salaries and employee benefits (Notes 6 and 7)	\$ 2,111,944	\$ 557,189	\$ 331,853	\$ 627,967	\$ 3,628,953
Equipment	6,541	16,440	-	15,499	38,480
Office supplies and services	37,791	33,841	19,397	127,404	218,433
Rent (Note 9)	237,270	-	-	78,819	316,089
Printing	975	1,216	-	6,673	8,864
Travel and meetings	190,084	118,408	20,251	27,181	355,924
Depreciation and amortization	81,329	-	-	36,206	117,535
Donations and sponsorship	-	1,500	-	-	1,500
Consultants and sub-contracted services	998,502	61,785	42,613	105,318	1,208,218
IT and computer	-	-	-	32,556	32,556
Miscellaneous	-	-	-	24,566	24,566
Sub-total	3,664,436	790,379	414,114	1,082,189	5,951,118
Allocation of overhead	699,791	65,617	-	(765,408)	-
TOTAL	\$ 4,364,227	\$ 855,996	\$ 414,114	\$ 316,781	\$ 5,951,118

ESSENTIAL HOSPITALS INSTITUTE
STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2014 AND 2013

	<u>2014</u>	<u>2013</u>
CASH FLOWS FROM OPERATING ACTIVITIES		
Changes in net assets	\$ (352,274)	\$ 5,316,773
Adjustments to reconcile changes in net assets to net cash provided by operating activities:		
Depreciation and amortization	51,209	117,535
Unrealized loss	18,594	-
Capitalized items reallocated towards contract	20,199	-
(Increase) decrease in:		
Grants receivable	1,036,688	(89,103)
Contracts receivable	64,740	(2,100,935)
Prepaid expenses	809	11,234
Increase (decrease) in:		
Accounts payable	(427,899)	(70,871)
Accrued salaries and related benefits	(2,435)	(5,693)
Deferred rent abatement	(25,751)	(12,703)
Due to America's Essential Hospitals	<u>877,265</u>	<u>(1,333,234)</u>
Net cash provided by operating activities	<u>1,261,145</u>	<u>1,833,003</u>
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of furniture and equipment	(4,108)	(44,613)
Purchase of investments	<u>(3,323,019)</u>	<u>-</u>
Net cash used by investing activities	<u>(3,327,127)</u>	<u>(44,613)</u>
Net (decrease) increase in cash and cash equivalents	(2,065,982)	1,788,390
Cash and cash equivalents at beginning of year	<u>6,844,285</u>	<u>5,055,895</u>
CASH AND CASH EQUIVALENTS AT END OF YEAR	\$ <u>4,778,303</u>	\$ <u>6,844,285</u>

See accompanying notes to financial statements.

ESSENTIAL HOSPITALS INSTITUTE

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES

Organization -

Essential Hospitals Institute, formerly the National Public Health and Hospital Institute (NPHHI), was incorporated on October 1, 1987, primarily to foster and promote research and analysis relating to the more efficient and effective organization, delivery and financing of public hospitals and public health care; to educate the general public concerning the need to finance and provide access to quality care for all citizens; to sponsor programs and projects which are in furtherance of the charitable, scientific and educational goals of Essential Hospitals Institute and America's Essential Hospitals, its supported organization within the meaning of IRC Section 509(a)(3); and to serve as a source of expertise and knowledge to the general public in matters uniquely affecting public hospitals.

The accounting and reporting policies of Essential Hospitals Institute are in accordance with accounting principles generally accepted in the United States of America and reflect practices appropriate to non-profit organizations. The more significant of these policies are described below.

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 -

Essential Hospitals Institute reports as cash and cash equivalents all cash and investments purchased with original maturities of less than three months.

Bank deposit accounts are insured by the Federal Deposit Insurance Corporation ("FDIC") up to a limit of \$250,000. At times during the year, Essential Hospitals Institute 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. Realized and unrealized gains and losses are included in investment income on the Statements of Activities and Changes in Net Assets.

Receivables -

Grant, contribution and contract receivables approximate fair value. Management considers all amounts to be fully collectible. Accordingly, an allowance for doubtful accounts has not been established.

Furniture, equipment and leasehold improvements -

Furniture and equipment purchases over \$1,500 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. Furniture and equipment purchased for specific purposes under a contract are being depreciated over the life of the related contract. Leasehold improvements are amortized over the life of the lease using the straight-line basis. The cost of repairs and maintenance is recorded as expenses as incurred.

ESSENTIAL HOSPITALS INSTITUTE

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES (Continued)

Contracts -

Contracts are considered to be available for unrestricted use, unless specifically restricted by the contractor. Revenue from cost reimbursable contracts is recognized to the extent that expenses have been incurred for the purpose specified by the contractor during the period.

Revenue from fixed price contracts is recognized based on the work performed in correlation to the deliverables of the contract.

Essential Hospitals Institute received a fixed price contract from the Department of Health and Human Services during fiscal year 2011, in the amount of \$11,752,541. The contract period of performance is over 24 months, which ended on December 8, 2013. Essential Hospitals Institute was awarded one 12-month option period for an additional \$5,760,735 of funding. The purpose of the contract is to develop and possibly implement a campaign designed to decrease patient harm. During the years ended December 31, 2014 and 2013, Essential Hospitals Institute recorded contract revenue from this specific fixed price contract in the amounts of \$5,493,808 and \$7,985,704, respectively.

Contributions and grants -

Contributions and grants are recorded as revenue in the year notification is received from the donor. Contributions and grants are recognized as unrestricted support only to the extent of actual expenses incurred in compliance with the donor-imposed restrictions and satisfaction of time restrictions. Contributions and grants received in excess of expenses incurred are shown as temporarily restricted net assets in the accompanying financial statements.

Income taxes -

Essential Hospitals Institute is exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for income taxes has been made in the accompanying financial statements. Essential Hospitals Institute is not a private foundation.

Uncertain tax positions -

For the years ended December 31, 2014 and 2013, Essential Hospitals Institute 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 Essential Hospitals Institute's 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 benefited.

ESSENTIAL HOSPITALS INSTITUTE

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES (Continued)

Net asset classification -

The net assets are reported in two self-balancing groups as follows:

- **Unrestricted net assets** include unrestricted revenue and contributions received without donor-imposed restrictions. These net assets are available for the operation of Essential Hospitals Institute and include both internally designated and undesignated resources.
- **Temporarily restricted net assets** include revenue and contributions subject to donor-imposed stipulations that will be met by the actions of Essential Hospitals Institute and/or the passage of time. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the Statements of Activities and Changes in Net Assets as net assets released from restrictions.

Risks and uncertainties -

Essential Hospitals Institute 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 accompanying financial statements.

Fair value measurements -

Essential Hospitals Institute 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. Essential Hospitals Institute accounts for a significant portion of its financial instruments at fair value or considers fair value in their measurement.

2. INVESTMENTS

Investments consisted of the following at December 31, 2014. There were no investments at December 31, 2013.

	<u>Fair Value</u>
Money market funds	\$ 96,452
Mutual funds - bond funds	737,121
Equities	964,959
Fixed income	<u>1,505,893</u>
	 <u>\$ 3,304,425</u>

Included in investment income are the following:

	<u>2014</u>	<u>2013</u>
Interest and dividends	\$ 42,021	\$ 9,118
Unrealized loss	<u>(18,594)</u>	-
Total investment income	<u>\$ 23,427</u>	<u>\$ 9,118</u>

ESSENTIAL HOSPITALS INSTITUTE
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013

3. GRANTS RECEIVABLE

As of December 31, 2014 and 2013, contributors to Essential Hospitals Institute have made written promises to give totaling \$365,134 and \$1,401,822, respectively.

Grants are due as follows at December 31, 2014 and 2013:

	2014	2013
Less than one year	\$ 365,134	\$ 1,037,971
One to five years	-	363,851
GRANTS RECEIVABLE	\$ 365,134	\$ 1,401,822

4. TEMPORARILY RESTRICTED NET ASSETS

Temporarily restricted net assets consisted of the following at December 31, 2014 and 2013:

	2014	2013
Time Restricted	\$ 589,818	\$ 1,996,060

5. NET ASSETS RELEASED FROM RESTRICTIONS

The following temporarily restricted net assets were released from donor restrictions by the passage of time, which satisfied the restricted purposes specified by the donors:

	2014	2013
Passage of Time	\$ 1,406,242	\$ 1,295,306

6. BOARD DESIGNATED NET ASSETS

As of December 31, 2014, net assets have been designated by the Board of Directors for the following purposes. There were no designated net assets as of December 31, 2013.

	2014	2013
Special purpose fund	\$ 3,300,000	\$ -
Operating reserve	900,000	-
BOARD DESIGNATED NET ASSETS	\$ 4,200,000	\$ -

7. 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).

ESSENTIAL HOSPITALS INSTITUTE

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

7. RELATED PARTY TRANSACTIONS (Continued)

Costs are allocated between the two organizations based on actual expenditures or a percentage of salaries. Essential Hospitals Institute's allocation of expenses was 50% for 2014 and 2013. During 2014 and 2013, costs allocated to Essential Hospitals Institute were \$3,960,347 and \$3,081,241, respectively, and the amounts paid by Essential Hospitals Institute to America's Essential Hospitals totaled \$3,083,082 and \$3,160,892, respectively. The 2013 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. There was no such contribution for the year ended December 31, 2014.

At December 31, 2014 and 2013, Essential Hospitals Institute owed \$932,272 and \$55,007, respectively, to America's Essential Hospitals.

8. RETIREMENT PLAN

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 2014 and 2013 totaled \$511,000 and \$417,200, respectively. Of those amounts, \$254,408 and \$211,523, respectively, were allocated to Essential Hospitals Institute (see Note 7).

9. CONCENTRATION OF REVENUE

For the years ended December 31, 2014 and 2013, approximately 100% and 98% of contracts revenue, respectively, and 99% and 77% of grants revenue, respectively, was derived from two organizations. Essential Hospitals Institute has no reason to believe that relationships with these organizations will be discontinued in the foreseeable future. However, any interruption of these relationships (i.e., the failure to renew grant agreements or withholding of funds) would adversely affect Essential Hospitals Institute's ability to finance ongoing operations.

10. COMMITMENTS

Essential Hospitals Institute is committed under an agreement for meeting space through the year 2015. The total commitments under the agreement are not determinable as it depends upon attendance and other unknown factors. There are cancellation penalties that would be due if the agreement were cancelled prior to the event date. The amount of the cancellation penalties increase through the date of the event.

11. LEASE AGREEMENT

In December 2011, America's Essential Hospitals, a related party organization (see Note 7), modified its existing lease agreement for additional office space to support the expansion of Essential Hospitals Institute activities. The agreement expires in December 2015, and provides for landlord-paid leasehold improvements in the amount of \$78,839. 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, 2014.

ESSENTIAL HOSPITALS INSTITUTE

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

11. LEASE AGREEMENT (Continued)

On March 4, 2015, America's Essential Hospitals entered into a fifteen-year agreement to lease new office space. Base rent is \$1,449,977, increasing by a factor of 2.5% per year. The lease includes fourteen months of abated rent in the the first two years of the lease.

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.

Total rent expense for the years ended December 31, 2014 and 2013 was \$312,033 and \$316,089, respectively.

America's Essential Hospitals is committed for future minimum lease payments under the expansion agreement.

12. FAIR VALUE MEASUREMENT

In accordance with FASB ASC 820, *Fair Value Measurement*, Essential Hospitals Institute 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. 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 Essential Hospitals Institute 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. These are investments where 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.

- *Money market funds* - The fair value is equal to the reported net asset value of the fund.
- *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.
- *Equities* - Valued at the closing price reported on the active market in which the individual securities are traded.
- *Fixed income* - 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.

ESSENTIAL HOSPITALS INSTITUTE

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

12. FAIR VALUE MEASUREMENT (Continued)

The table below summarizes, by level within the fair value hierarchy, Essential Hospitals Institute's investments as of December 31, 2014:

Asset Class:	Level 1	Level 2	Level 3	Total December 31, 2014
Money market funds	\$ 96,452	\$ -	\$ -	\$ 96,452
Mutual funds - bond funds	737,121	-	-	737,121
Equities	964,959	-	-	964,959
Fixed income	-	1,505,893	-	1,505,893
TOTAL	\$ 1,798,532	\$ 1,505,893	\$ -	\$ 3,304,425

Essential Hospitals Institute did not have any investments as of December 30, 2013.

13. SUBSEQUENT EVENTS

In preparing these financial statements, Essential Hospitals Institute has evaluated events and transactions for potential recognition or disclosure through May 13, 2015, the date the financial statements were issued.



DATE June 12, 2015
TO Board of Directors
FROM Stan Hammack, Membership Committee Chair
RE Membership Committee Report

MEMORANDUM

On behalf of the membership committee, I am pleased to share with you this update of the committee's activities.

Since the March board meeting, the committee met twice by teleconference/webinar. During these meetings, the committee discussed the roll out of the new dues structure, which is going well; discussed ongoing recruitment and retention activities; and worked with staff to develop a proposed membership plan for 2015-2018, which is detailed below.

The board is asked to accept the proposed membership plan.

Executive Summary

In 2012, the board of directors of America's Essential Hospitals approved a comprehensive growth and governance plan to provide a framework for the association's recruitment and retention activities. Since then, the association has seen accelerating growth in the number of members, with 31 health systems joining. Additionally, the governance structure of the association was significantly expanded by adding more than a dozen committees that formally engage more than 150 individuals across the membership.

The association also created a new strategic plan, rebranded, updated its bylaws, and changed its dues structure. These activities have served to strengthen the association's ability to reach new audiences and be more effective in advocating for a particular set of hospitals: those serving vulnerable populations, with a teaching mission, providing a breadth of services, and with a deep community connection.

With this strong foundation, staff have prepared an updated plan to provide direction for the next three years. These are key features of the plan:

1. Recruitment

Recruitment would largely continue to build on the achievements of the past three years, using many of the proven marketing and outreach techniques that have led to success.

Additionally, focus will be placed on recruiting within certain geographic areas and small hospitals.

2. Retention

Retention efforts will center on fully integrating new members, communicating early and often about member benefits, and assessing programming and services to meet needs of the full C-suite, as well as staff just below the C-suite.

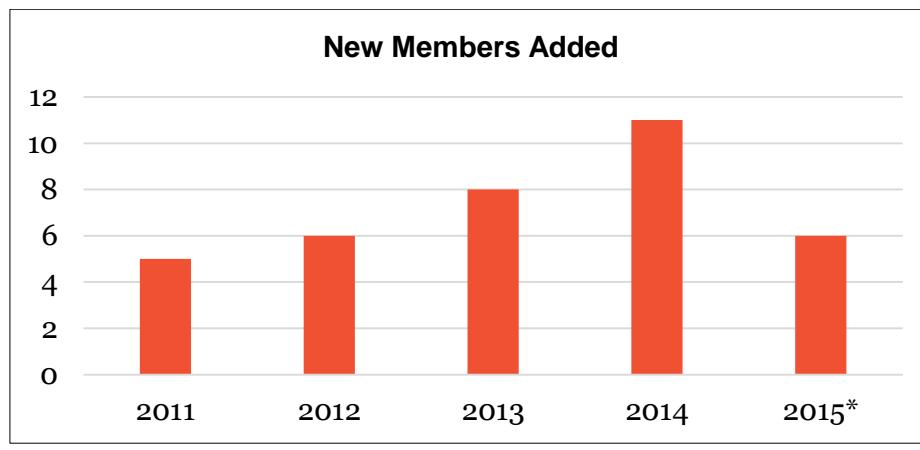
3. Member engagement

Member engagement will focus on fully leveraging the association's participation index and considering new, short-term ways to engage members.

How the Association Delivered on its 2012 Plan

• Recruitment

The board of directors have set an explicit goal to grow the association. To achieve this objective, the 2012 plan laid out a dual-pronged effort to add new members, including both direct mail to a large set of prospective members, along with intensive individual outreach to a smaller set of prospects. To that end, staff have conducted a quarterly direct mail campaign to approximately 350 prospective hospitals. Additionally, staff have maintained a steady drum beat of focused, one-on-one outreach to a hot prospect list of approximately 100 hospitals. And finally, with the establishment of the membership committee, volunteers have been increasingly engaged in membership recruitment activities. Recruitment of more than half of all new member hospitals and systems in the past five years happened with the assistance of the membership committee and other volunteer leaders from member hospitals.



The association has sought to add members in states where we had no presence. Among those targeted states, members were added from Arkansas, Maryland, North Carolina, Oklahoma, Pennsylvania, South Carolina, and West Virginia.

Another priority was to bring past members back into the fold. Among lapsed members, the following have reinstated their membership:

-
- Erie County Medical Center (Buffalo, New York)
 - University of Missouri (Columbia, Missouri)
 - University of Illinois (Chicago)
 - University of Chicago (Chicago)
 - Erlanger Health System (Chattanooga, Tennessee)
 - UAMS Medical Center (Little Rock, Arkansas)
 - University of Mississippi (Jackson, Mississippi)
 - Interim LSU (New Orleans)

- **Retention**

Another key component of the 2012 plan was to establish a solid foundation of activities to ensure the retention of all members, with a special focus on new members. As a result, staff established a variety of new routines, including these:

- a one-hour introductory phone call with senior leaders of each new member
- a system to send targeted invitations to participate in key activities, such as VITAL, Policy Assembly, the Fellows Program, the Government Relations Academy, and the Essential Hospitals Engagement Network (EHEN)
- a welcome call from association's president and CEO to all new CEOs at existing member hospitals and systems
- an annual member benefits usage summary each fall

- **Member engagement**

The final area of focus in the 2012 plan was to develop a comprehensive system to engage members through substantive programming, as well as committees. This was achieved in three ways:

- We established an extensive system of committees and interest groups. Among these units, more than 150 individuals are engaged as volunteer leaders with the association. Additionally, staff developed committee charters, position descriptions, and terms of service, and established a formal board orientation process.
- We conducted a call for proposals process for VITAL2015, which resulted in 79 submissions from 38 member hospitals.
- We developed a quantifiable Member Engagement Index that gauges participation in four areas: education, governance, assessments, and submissions. We have used the data to identify low-participation members for focused outreach to encourage additional uptake of member benefits.

- **Membership diversity**

The 2012 plan identified a potential challenge as a result of membership diversity: conflicting priorities among members for our widely varied services and advocacy priorities. Staff have paid close attention to this risk, and with a more diverse membership, the association has broadened its advocacy issues and programming, but remains aligned in focusing all its activities on five key member characteristics: caring for the most vulnerable, training future health care leaders, providing comprehensive coordinated care, providing specialized lifesaving services, and advancing public health.

Context/Environment

In 2012, advocacy was seen as the association's highest-value service, and the association continued to enjoy a good reputation on Capitol Hill. The association also enjoyed strong financial health and had just begun to develop new service lines, primarily in the quality and performance improvement arenas. Today, the association has grown significantly, both in scope and size. Advocacy generally remains the leading reason for joining the association, but members are increasingly looking to the association for expertise in new areas, such as state Medicaid waivers, population health, and equity issues, including advocacy for sociodemographic risk adjustment and disparities reduction.

With the changing composition of Congress, there are new and renewed threats to entitlement programs on the horizon. With the continued roll out of the Affordable Care Act (ACA), the importance of regulatory guidance has increased since 2012. And finally, new financial penalties associated with performance and value-based purchasing are ramping up, with members often seeing low ratings and disproportionate penalties.

Advocacy efforts and challenges going forward are grouped into short-, medium-, and long-term issues:

- Short-term issues
 - Medicaid disproportionate share hospital (DSH)
 - Medicaid expansion
 - risk adjustment
- Medium-term issues
 - 340B Drug Pricing Program
 - Medicare outpatient payments
 - Medicare DSH
 - Graduate Medical Education
 - entitlement reform
 - continued ACA litigation (e.g., King v. Burwell)
- Long-term issues
 - accountability
 - coverage expansion
 - state-driven innovations
 - reducing costs

As reported to the board in March, membership health is strong but requires continued monitoring.

- Members are generally satisfied, have a high likelihood of recommending the association, and find the value of membership equaling or exceeding the cost of dues.
- Responses to, and outcomes of, the association's rebranding are positive.
- Advocacy and information sharing are important benefits, with a growing interest in quality and performance improvement activities.

-
- While decision-makers seem to know the association well, non-decision-makers have a more vague understanding of the association's value and need to be more proactively and regularly engaged.

Proposed Scope of Work for 2015-2018

Building on the success of the work outlined in the 2012 plan, the following initiatives are proposed for 2015-2018.

Member Recruitment

With an objective to continue to grow smartly, staff and volunteers will continue to implement a two-pronged approach for recruitment: direct mail to a large prospect list, coupled with one-on-one outreach for a smaller, targeted list. The key will be to use strict metrics for identifying prospects to ensure issue alignment. Staff will use various metrics, such as Medicaid and Medicare payer mix, DSH Patient Percent (DPP), discharges, etc., to screen for prospective members. We will overlay the data with an assessment of the hospital's commitment to serving vulnerable populations, teaching mission, acuity of services, and innovative practices and/or commitment to transformation.

- Priorities: While all hospitals on the prospect list will be targeted, special attention will be given to these:
 - the handful of state academic medical centers not in the membership
 - geographic areas based on congressional relevance
 - geographic areas with no members, in particular: Hawaii, Iowa, Nebraska, New Hampshire, Maine, and Vermont
- Small hospitals
With the new dues structure, it is now more financially feasible for smaller hospitals to join the association. A campaign specifically designed to recruit smaller hospitals would be launched during this period. The campaign would include messaging that addresses unique needs among this subsegment.
- End of low hanging fruit
Staff have already begun to see the sales cycle become tougher as they encounter more hospital leaders who indicate support our work but, for a variety of reasons, a small likelihood of joining us. Those reasons include a reduced commitment to associations, a general posture of not joining associations, and budget restrictions. New strategies should be explored to account for this shift in prospect profile.

Member Retention

Building on activities already in place, staff propose to focus retention activities on the following:

- **Large cohort of new members**

Several strategies to completely integrate new members into the association's culture are being developed and will be implemented in the coming months. These efforts include several communications over the first six months of membership and will strive to ensure strong points of contact across several positions. Staff from across the association have committed to assisting with these efforts.

- **CEO needs versus those of other staff**

While the CEO and government relations staff are still primary audiences within each member hospital, it is proposed to consider programming, services, and communications that would be of interest to others within the C-suite, as well as the next level down. An effort should be undertaken to better understand the needs of emerging leaders and how their needs differ from those of others.

Staff have been cautioned, though, to focus on core policy/advocacy issues, financing, leadership development, and performance improvement topics, while avoiding operational topics that are well-served by other associations or entities (e.g., UHC).

- **Communicate benefits more often**

Volunteers have advised staff that more should be done to communicate member benefits. It is suggested that more frequent statements should be shared through a variety of channels. A robust schedule of communications will be developed and implemented in 2016.

Member Engagement

The key to membership engagement will be to fully incorporate a variety of individuals within each member hospital into the association's activities, as well as closing the loop and telling the CEO how participating on a committee, task force, etc., helped the hospital.

- **Member Engagement Index (MEI)**

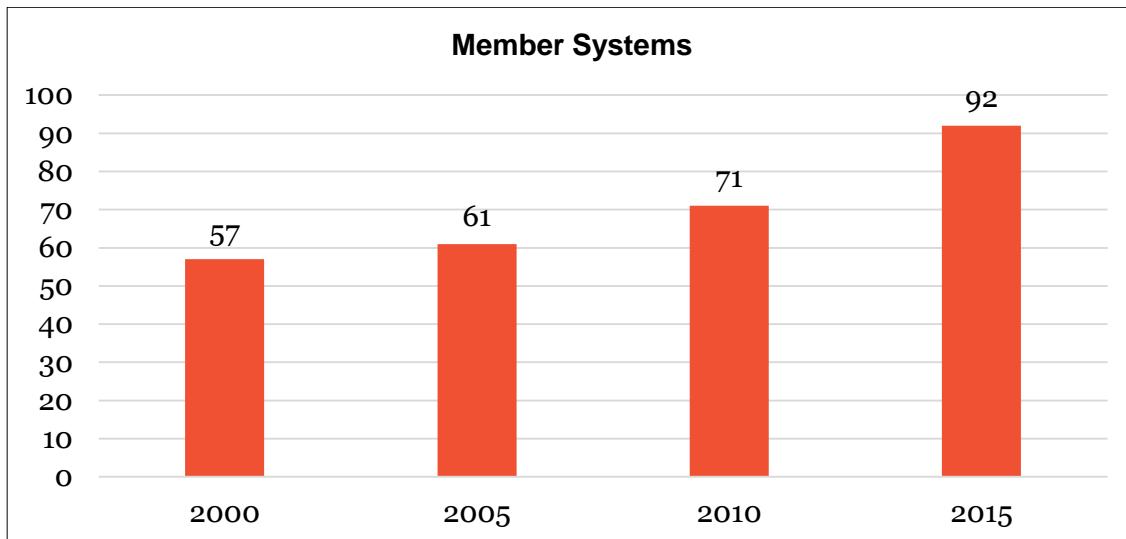
Staff will focus on the MEI as a mechanism for identifying those members who are not broadly taking advantage of their member benefits. This index will be reviewed on a regular basis to continually inform staff and volunteers which members need personalized attention to maximize their participation in the association.

- **Short-term/ad hoc engagement**

While the association will continue its committee and board structure, new opportunities for short-term, ad hoc engagement will be explored. These might include focus groups, task forces, or similar activities that do not require the lengthy time commitment of a traditional committee. These new opportunities may also take advantage of technical expertise outside the C-suite and would often have concrete deliverables at the end of the project.

Appendix A: Membership Statistics

Membership count over time



Length of membership

Number of Years	% of Total Membership (2012)	% of Total Membership (2015)
< 5	19%	35%
5-10	11%	11%
11-15	17%	11%
> 15	53%	43%

Members by patient discharges

Discharges	% of Total Membership (2015)
less than 10,000	30%
10,000 - 19,999	27%
20,000 - 29,999	29%
30,000 - 39,999	10%
40,000 - 49,999	2%
50,000 or greater	2%

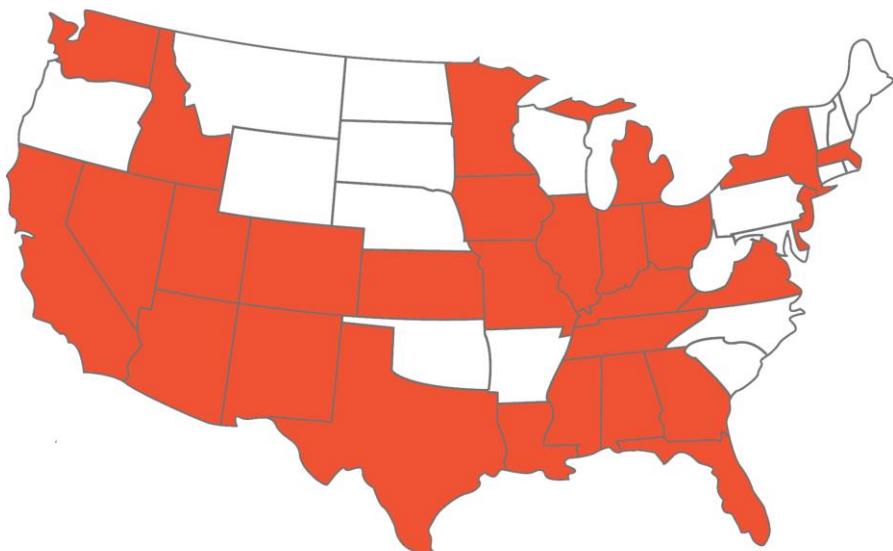
Members by expenses

Expenses	% of Total Membership (2015)
< \$250M	14%
\$250M - < \$750M	42%
\$750M - < \$1.5B	31%
\$1.5B - < \$3B	9%
\$3B <	3%

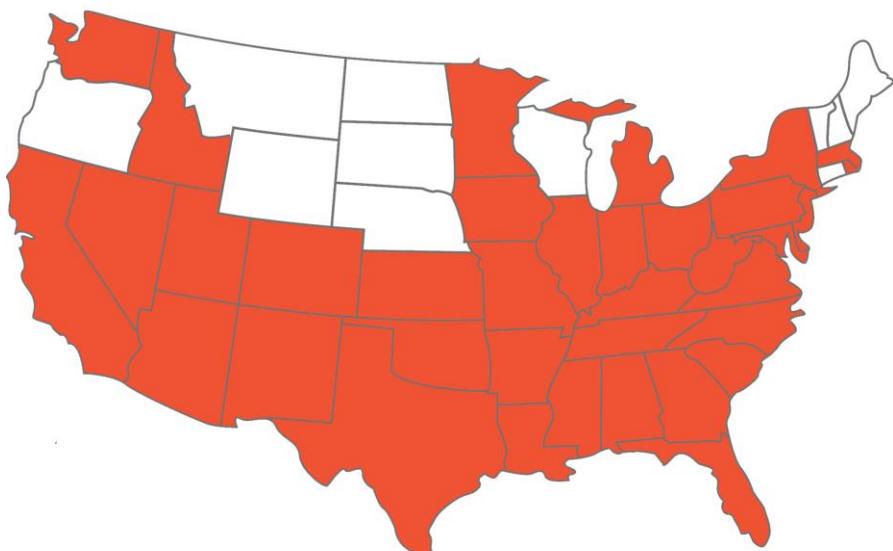
Geographic Coverage

As depicted in the maps below, the association's geographic coverage has grown by nearly 30 percent from 2012 to 2015.

States with member hospitals/health systems in 2012:



States with member hospital/health systems in 2015:



Appendix B: Committee Roster, July 1, 2014 - June 30, 2015

Stan Hammack – Chair (2014-2016)
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Santiago Muñoz, III (2014-2016)
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James N. Valenti (2013 -2015)
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DATE June 12, 2015
TO Board of Directors
FROM Michael Belzer, MD, Education Committee Chair
RE Education Committee Report

MEMORANDUM

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

Annual Conference

- **VITAL2015**

As of June 8, 261 individuals had registered for the conference. Staff will provide an updated registration count during the board meeting.

This year's program features several sessions on state Medicaid waivers, as well as a variety of sessions on sociodemographic factors, including treating the homeless, food insecurity, gender and sexual diversity, and race, ethnicity, and language (REL).

- **VITAL2016**

Next year's annual conference will be in Boston, June 15 to 17. To support program development, we again will conduct a call for proposals (CFP) this fall. The committee and staff have identified a few minor modifications based on this year's successful CFP.

State Medicaid Waivers

Throughout 2015, the association is conducting a multipronged work plan focused on state Medicaid waivers, including these initiatives:

- development of a national message that makes the case for waivers and their benefit to delivery system reform and payment models
- enhanced visibility on the association's website with a "one-stop shop" landing page of waiver resources.
- three breakout sessions at VITAL2015

-
- a one-day summit, September 21, in Chicago, to include two tracks on Medicaid waiver activities and a featured speaker from the Centers for Medicare & Medicaid Services (CMS)
 - a five-part distance learning series with a special emphasis on hospital and community health centers, developments from CMS, and other trends
 - a research brief on the key elements of success in waivers, especially the positive impact on lives saved and costs avoided

Fellows Program

Thirty-nine fellows from 21 organizations are enrolled in the 2015-2016 Fellows Program. A new fellows orientation session was held on May 12. Fellows have been given pre-class assignments and will meet with their sponsors before the program's first session, at VITAL2015, in San Diego. A site visit has been scheduled for UC San Diego Health (Hillcrest Medical Center).

Innovations Summit

The Innovations Summit showcases for policymakers and influencers innovative member programs. This year's summit will be October 15, in Washington, DC, and the program will focus on the integration of behavioral health and primary care. Staff have confirmed Linda Rosenberg, president and CEO of the National Council for Behavioral Health, as the program's opening keynote speaker. The event will feature member programs, including at UMass Memorial Health Care, in Worcester, Massachusetts, and Harris Health System, in Houston.

Also at the summit, Essential Hospitals Institute will release a research brief featuring five member programs:

- UMass Memorial Health Care
UMass participates in the Massachusetts Primary Care Payment Reform program, a three-year, state-funded initiative that aims to integrate behavioral health into the patient-centered medical home through alternative payment strategies and quality incentives. UMass also has implemented the Massachusetts Child Psychiatry Access Project, which provides telephonic psychiatric and clinical guidance to primary care providers who treat children with mental health problems.
- Harris Health System
Harris Health first implemented its Community Behavioral Health program in 2004. The program began as a pilot in three community health centers and has expanded multiple times since to match the health system's growth. Harris now has behavioral health services in more than 12 primary care centers, two school-based clinics, homeless programs, and various other locations.
- NuHealth, East Meadow, New York

NuHealth integrates primary care into outpatient mental health clinics to provide annual physical exams and care coordination to patients seeking mental health services.

NuHealth also has focused specifically on integrating mental health services into primary care for the geriatric population through a 2011 grant from the New York State Office of Mental Health.

- University of Texas Medical Branch (UTMB), Galveston

UTMB's St. Vincent's Hope Clinic provides primary care to patients of all ages through a nurse-managed health clinic. St. Vincent's opened in 2008 and specifically focuses on patients with chronic conditions in need of accessible and consistent care. The clinic provides access to nurse case management services and counseling/mental health services through partnerships with the UTMB Community Health Program and the local Family Services Center.

- Santa Clara Valley Health & Hospital System, San Jose, California

Santa Clara works through the state's Delivery System Reform Incentive Payment program to integrate behavioral health and primary care throughout the system. Using the IMPACT model, care teams co-locate at five clinics and use depression screening (PHQ-9 tool) to identify patients who need behavioral health services. Results from the program show increased identification and treatment of patients' behavioral health needs across diverse groups.

Appendix A: Committee Roster, July 1, 2014 – June 30, 2015

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

Sherrie D. Williams, MD, MHS
Vice Chair (2014-2016)
Medical Director of Pulmonary
Rehabilitation and Smoking Cessation
The MetroHealth System
Cleveland

D. Craig Cathcart, RN (2013-2015)
Director of Legislative Affairs and Advocacy
Swedish Covenant Hospital
Chicago

Theodore Chan, MD (2013-2015)
Chair of Emergency Medicine
UC San Diego Health System
San Diego

Susan R. Cooper, MSN, RN (2014-2016)
Chief Integration Officer, Senior Vice
President of Ambulatory Care
Regional One Health
Memphis, Tennessee

Susan A. Currin, RN, MS (2014-2016)
CEO
San Francisco General Hospital and Trauma
Center
San Francisco

Delvecchio S. Finley, MPP (2014-2016)
CEO
Harbor-UCLA Medical Center
Torrance, California

James R. Gonzalez, MPH (2014-2016)
President and CEO
University Hospital
Newark, New Jersey

Thomas J. Quattroche, PhD (2013-2015)
Senior Vice President of Marketing,
Planning and Business Development
Erie County Medical Center
Buffalo, New York

Arnold Tabuenca, MD (2013-2015)
Chief Medical Officer
Riverside County Regional Medical Center
Hospital Administration
Moreno Valley, California

Joseph Woelkers, MA (2013-2015)
Executive Vice President and Chief of Staff
UT Health Northeast
Tyler, Texas



DATE June 12, 2015
TO Board of Directors
FROM John Haupert, Chair, Policy Advisory Committee
RE Policy Advisory Committee Update

MEMORANDUM

On behalf of the policy advisory committee, I provide this update of the committee's activities and present an action item for the board's consideration: approval of draft principles on pricing transparency.

America's Essential Hospitals has monitored the growing trend to increase transparency of health care prices, particularly as consumers and patients assume greater financial responsibility for their care. This issue has been a topic of media reports and scrutiny. The Centers for Medicare & Medicaid Services (CMS) also has started publishing more financial information, such as Medicare payment information for specific providers. Due to complexities with third-party payment and other issues, the type of information publicly available may not be useful to consumers or allow them to truly understand the cost of their care.

America's Essential Hospitals recognizes that the issue of pricing transparency will continue to be debated and hospitals will face pressure to make pricing more transparent. Many national and state hospital and hospital-related groups have engaged in drafting principles and identifying approaches for greater transparency. We recognize that transparency impacts essential hospitals differently than other hospitals and that our members have a unique perspective on this issue. Our draft principles aim to capture those distinctions. It will help the association and its members to have well-crafted principles that staff can share during upcoming discussions and debate on this issue.

The pricing transparency principles are attached to this memo (Attachment A) and will be presented to you during the June 23 meeting for your review and approval.

Attachment A

Draft Principles on Pricing Transparency May 2015

In recent years, policymakers, the media, and the public have started discussing efforts to increase transparency of health care prices. Several national and state hospital-related organizations have developed price transparency principles to provide a framework for these discussions. America's Essential Hospitals believes these efforts have laid a solid foundation for discussions of pricing transparency.¹

However, the patients whom essential hospitals serve, and the social, linguistic, and economic obstacles they face, present special challenges that warrant principles specific to essential hospitals. For example, patients in low-income communities might have limited access to primary care, prescription drugs, or transportation to clinic appointments, among other social issues. Essential hospitals are committed to caring for these patients, but it is clear that caring for patients with significant social and economic needs may result in higher costs at essential hospitals.

Through their integrated health systems, members of America's Essential Hospitals offer the full range of primary through quaternary care, including trauma care, outpatient care in ambulatory clinics, public health services, behavioral health and substance use disorder services, and wraparound services crucial to vulnerable patients. Communities, as well, rely on these needed services. But these services also may contribute to higher costs at essential hospitals. With these critical issues in mind, America's Essential Hospitals urges policymakers to consider the following principles when discussing price transparency initiatives or policies:

- 1) **Any information made available to the public must explain how and why the cost of patient care varies among hospitals.** Hospitals that take on the provision of services that are vital to the community, such as trauma or behavioral health care, will have higher costs. That is especially true for essential hospitals. These hospitals provide services not typically provided by other hospitals, including, but not limited to, community clinics; neonatal services; and wraparound services, such as social services, interpretation, or even access to food and shelter to patients who otherwise would not have these necessities. Much of this care is provided to vulnerable populations, who are often uninsured. This leaves essential hospitals to shoulder the costs of the uncompensated care provided to these patients. Essential hospitals also are committed to teaching, and are training the next generation of physicians, further increasing the cost of care.
- 2) **Each patient's out-of-pocket costs must be communicated to the patient individually.** Providers must work in partnership with insurers to communicate to patients about their financial responsibilities. This individualized communication should be done in a timely manner, in the language the patient prefers, and in a format the patient can understand.

¹ In particular, the pricing transparency principles and guidelines from the Healthcare Financial Management Association, the Illinois Hospital Association and the Healthcare Association of New York State.

-
- 3) **Patients should receive adequate and clear information and support regarding financial assistance with the cost of their care so that the fear of responsibility for all or part of a health care bill does not cause a patient to forgo necessary care.** While essential hospitals strive to connect eligible individuals to coverage, they acknowledge that some individuals will be ineligible for coverage or slip through the coverage cracks. Essential hospitals are proud of their mission to provide access to quality care for all. They recognize that interacting with the health care system can be daunting to some individuals, and they strive to implement not only robust charity care policies, but also provide financial navigation assistance to patients who need it.
 - 4) **Essential hospitals, payers, their states, and the federal government should partner to address challenges to price transparency.** Essential hospitals strive to be transparent about quality of care, patient experience, and price. However, transparency efforts are often limited by antitrust concerns, confidentiality agreements, and regulatory barriers.

Attachment B: Committee Roster, July 1, 2014 – June 30, 2015

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DATE June 12, 2015
TO Board of Directors
FROM Beth Feldpush, DrPH, Senior Vice President of Policy
and Advocacy
RE Policy and advocacy update

MEMORANDUM

This memo outlines advocacy and policy activities of America's Essential Hospitals since the March 2015, in-person board meeting, and provides an outlook for the remainder of the year.

A Busy Spring: SGR Repeal, DSH Delay, 340B Threat

Congress had a busy spring with respect to health care legislation, passing one bill of particular interest to essential hospitals and advancing another through the committee process.

On April 16, President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) into law. In addition to many critical provisions for essential hospitals—including an additional year delay of Medicaid disproportionate share hospital (DSH) payment cuts—the legislation averted a pending 21 percent payment cut to Medicare physicians by repealing the sustainable growth rate (SGR) formula. In its place, MACRA creates a new annual Medicare physician service fee schedule; develops a new quality reporting system, the Merit-based Incentive Payment System (MIPS), which combines and replaces existing quality reporting programs; and bolsters the development and use of alternative payment models (APMs) under which physicians may choose to be paid beginning in 2019.

MACRA's new physician fee-for-service updates provide a small annual increase of 0.5 percent from 2015 through 2019, no updates from 2020 through 2025, and a 0.25 percent update starting in 2026. These minimal increases in payment are intended to encourage physician participation in APMs, in which physicians would receive a 0.75 percent annual payment adjustment, as well as potential bonus payments based on their performance in approved APM models. Congress left broad discretion to the administration in determining approval of APMs, guidelines around provider participation, and other policies necessary to administer the new payment models.

For members of America's Essential Hospitals, MACRA provided the vehicle for a significant legislative victory: an additional year delay to the start of Affordable Care Act (ACA) cuts to Medicaid DSH payments, now schedule to begin in fiscal year (FY) 2018.

This is the third time Congress has delayed Medicaid DSH cuts. The additional year delay gives essential hospitals vitally needed breathing room to survive uneven coverage expansion and

persistently high levels of uncompensated care, and allows them to continue serving vulnerable patients.

The schedule of DSH cuts in MACRA also provides relief for essential hospitals over the next five years compared with current law. The ACA originally would have cut DSH by more than \$17 billion from 2014 to 2020. Under the new law, the cuts each year during that span are lower, totaling \$9 billion—nearly half the original reduction. However, cuts in the “out years”—beyond FY 2020—are now larger than previously enacted, ultimately reaching \$8 billion annually in FYs 2023 and 2024. This is the new DSH cut schedule:

Fiscal year	Cut
2014	\$0
2015	\$0
2016	\$0
2017	\$0
2018	\$2 billion
2019	\$3 billion
2020	\$4 billion
2021	\$5 billion
2022	\$6 billion
2023	\$7 billion
2024	\$8 billion
2025	\$8 billion
Total	\$43 billion

Congress Examines 340B Program, Considers Changes

In late March, the House Committee on Energy and Commerce held a hearing to examine the 340B Drug Pricing Program. More than 31 organizations submitted statements, letters, and documents about the program for the record, including America’s Essential Hospitals. The witness panel included representatives from the Health Resources and Services Administration (HRSA), the Government Accountability Office (GAO), and the Office of the Inspector General (OIG).

The hearing focused on the need for increased transparency and accountability for program participants, with special attention given to patient definition, hospital eligibility, compliance, reporting, and use of program savings. During the hearing, there seemed to be consensus among committee members that 340B is a valuable program, but that a need exists for enhanced HRSA oversight of and clarity on the program.

Following the hearing, the focus on 340B seemed to subside on the Hill. There was little discussion about the program or activity signaling legislative changes to the program. HRSA’s long-awaited guidance is still pending, and has recently been sent to the Office of Management and Budget (OMB) for review. Congressional representatives stated that no action would be taken until the agency had released its clarifying guidance.

Nevertheless, on May 15, America’s Essential Hospitals learned that the Committee on Energy and Commerce’s focus on 340B had resurfaced, with plans to take significant legislative action as part of the 21st Century Cures legislative package, scheduled for committee action May 20. The proposed 340B language would have effectively overhauled federal administration and oversight of the program. With an exceedingly tight timeframe, the committee released the 340B legislative language to a select group of stakeholders, including America’s Essential Hospitals, with a request for comments and feedback within less than one business day. The association complied by submitting a letter with detailed comments about the proposal and noting concerns about several provisions:

- **New patient definition** – narrowing the scope of individuals to which essential hospitals can provide drugs.
- **Enhanced penalties for violations** – mandating a minimum five-year exclusion period for covered entities that intentionally violate diversion or duplicate discount requirements, and creating new authority to exclude covered entities for a minimum of five years for not taking corrective action in a “timely manner.”
- **Excluding eligibility of certain covered entity programs that also serve as correctional facilities and prohibiting transfer of “revenue” from 340B drugs to correctional facilities** – while the language was broad and unclear, it would have potentially disrupted existing programs through which essential hospitals ensure health care for correctional facilities inmates.

The association commented on these provisions, along with several others, as it negotiated with the committee. At the same time, we alerted member hospitals of the proposal and called on them to urge their congressional representatives to halt the proposal and allow adequate time for review and feedback from hospitals and 340B program covered entities. But the committee continued pushed forward and released revised language after working closely with America’s Essential Hospitals and other stakeholders to amend the proposal.

While the committee adjusted the proposal to reflect some of the association’s recommendations, the revised language still presented significant concerns. Given the outstanding and potentially harmful provisions, the association chose to oppose the proposal outright. It urged the committee to reject the effort altogether and again called on member hospitals to request that the committee pull the measure from the 21st Century Cures bill. After several days of working closely with the committee and repeated outreach to voice essential hospitals’ concerns, America’s Essential Hospitals successfully helped sway the committee to pull the language from the parent bill, only hours before its consideration.

The committee has agreed to ongoing work with America’s Essential Hospitals and other 340B program stakeholders to craft consensus-based legislation to improve the program. The association welcomes further discussion and looks forward to continuing to work with congressional staff on any changes to the 340B program.

The Long-Term Outlook for 2015

Our current top issues—the 340B program, risk adjustment for sociodemographic status, protecting Medicaid from potential cuts, and protecting Medicare outpatient payments—will

remain priorities for 2015. At the same time, we also plan to take on new issues, including potential legislation on health care disparities.

While tackling health care disparities has been a priority in the association's research and quality improvement realms, we are beginning work to develop legislation that would provide financial support to essential hospitals actively working to address health care disparities in their communities. We look forward to sharing our progress on this important effort with you as we move forward.

In addition to these efforts, we are preparing to respond to new threats this year—particularly to Medicaid during the upcoming budget negotiations. Congressional Republicans have indicated they may propose damaging cuts to Medicaid as part of a special procedure that allows lawmakers to fast-track legislation during the budget process. In April, Republican leaders of the committees that oversee Medicaid sent a letter to the Medicaid and CHIP Payment and Access Commission (MACPAC) asking commissioners to “advise Congress about potential policies and needed financing reforms and incentives to ensure the sustainability of the [Medicaid] program.” Congressional Democrats, in turn, sent a letter to MACPAC asking for other policy options to protect and strengthen the program. While we expect the president would veto a major overhaul of the program, other significant changes might become reality and set the stage for future Medicaid cuts. This is especially concerning, given the uncertain environment in which essential hospitals operate: one of persistent uncompensated care, especially in states that have not expanded Medicaid.

Additional threats could further reduce access to coverage, in particular the outcome of the *King v. Burwell* case. The case, which was argued in front of the Supreme Court in March, challenges the lawfulness of tax-credit subsidies to individuals who purchase coverage through federally run ACA marketplace plans. The Robert Wood Johnson Foundation and the Urban Institute recently estimated that, should the plaintiffs prevail, an additional 8.2 million people in the United States would go uninsured, and uncompensated care costs would rise by \$12 billion.

We expect the court to issue its ruling at the end of June. If the court sides with the plaintiffs and declares tax-credit subsidies impermissible in federally run marketplaces, it is unclear whether and how either the Obama administration or Congress would react. As of now, Senate Republicans seem to be coalescing around legislation introduced by Sen. Ron Johnson (R-WI). This legislation would maintain subsidies to purchase health insurance coverage through federally run marketplaces through the end of August 2017. However, the bill would also repeal the ACA's individual mandate and employer mandate, and remove the requirement that health plans cover essential health benefits, which would make it nearly impossible for Democrats to support the bill. We will be prepared to share relevant information and analysis with members on the ruling when it comes out in late June.

Meanwhile, Congress and the administration seem to be renewing their focus on oversight of Medicaid safety net financing—particularly non-DSH supplemental payments. In May, Rep. Chris Collins (R-NY) introduced legislation that would increase scrutiny of non-DSH supplemental payments and, if enacted, could lead to disallowances of some Medicaid upper payment limit (UPL) payments. If broadly interpreted, the legislation also could affect the ability of states to use uncompensated care pools and Delivery System Reform Incentive Payment (DSRIP) programs as part of future Section 1115 waivers.

Also, CMS' long-awaited regulation on Medicaid managed care includes further restrictions on the ability of managed care plans to pass on UPL payments. And the agency's newest regulatory agenda, which outlines potential regulatory work for the next 12 months, includes a rule on supplemental payments—specifically, to ensure that they meet the “economy and efficiency” standard. The rule would require that supplemental payments be “distributed proportional to the volume or cost of services delivered or be tied to meeting performance benchmarks.” While the renewed interest in supplemental payments is just emerging, it could represent the most significant threat to safety net financing since the end of the Bush administration.

Our work this year isn't purely defensive, though. We are also engaging in a large-scale media campaign to celebrate the 50th anniversary of the Medicaid program, which is July 30. The Partnership for Medicaid, a coalition of 23 national provider organizations, chaired by America's Essential Hospitals since 2012, is spearheading an effort to raise awareness about the Medicaid program and to urge Congress to preserve and strengthen it. The association and the coalition look forward to sharing our work on this important celebration with you next month.

Other Issues in Depth

Ongoing Advocacy on Adjustment for Sociodemographic Status

This spring, a bipartisan group of House and Senate lawmakers introduced identical bills requiring risk adjustment for sociodemographic status in the Medicare Hospital Readmissions Reduction Program (HRRP).

The legislation, the Establishing Beneficiary Equity in the Hospital Readmission Program Act (S. 688 and HR 1343), would ensure the HRRP does not unfairly penalize hospitals for vulnerable patients' social, economic, and other circumstances beyond a hospital's control. It was introduced in the Senate by Sens. Joe Manchin (D-WV) and Rob Portman (R-OH), and in the House by Reps. Jim Renacci (R-OH) and Eliot Engel (D-NY). The bill currently has eight cosponsors in the Senate and 40 in the House.

America's Essential Hospitals supports the legislation and is actively advocating for committees of jurisdiction to consider this bill. We are working to educate Congress about the need for risk adjustment across pay-for-performance programs. The legislative affairs team is engaging bill champions, committee staff, and leadership on this issue, and encouraging committees to take up the bill alone or as a part of existing, moving legislation.

Medicare Inpatient Payments

In April, CMS issued its annual proposed rule on the Medicare Inpatient Prospective Payment System (IPPS) for FY 2016. The rule covers the annual payment update to hospitals, Medicare DSH payments, and changes to the four inpatient quality improvement programs. CMS also briefly addressed the two-midnight policy and payment policy for short inpatient stays, acknowledging the Medicare Payment Advisory Commission's recent recommendation that CMS withdraw the two-midnight policy. The agency said it will discuss issues surrounding payment for short inpatient stays and long outpatient stays in this year's Outpatient Prospective Payment System proposed rule.

CMS proposed to increase IPPS rates for acute care hospitals by 1.1 percent in FY 2016. Total projected Medicare DSH payments in FY 2016 are \$9.71 billion, \$1.28 billion less than last year. The reduction in DSH payments stems from ACA-mandated cuts to DSH funding based on the national reduction in the uninsurance rate. In our comments to CMS, we continued to provide comprehensive recommendations on the accuracy of the data elements captured on worksheet S-10 of the Medicare cost report, which the agency is considering to use to determine uncompensated care for targeting Medicare DSH payments. America's Essential Hospitals is concerned about the growing size of the ACA-mandated cuts to Medicare DSH funding. Although we support the policy goal to redirect and target Medicare DSH funding to those hospitals that serve a larger proportion of low-income patients, we know that, over time, the size of the cuts will have a negative financial impact on most, if not all, of our members.

The agency also continued to propose new measures for the Readmissions Reduction, Hospital-Acquired Condition Reduction, Value-Based Purchasing, and Inpatient Quality Reporting programs. We continue to advocate for the use of risk adjustment for sociodemographic factors in CMS-run quality improvement programs, particularly the Readmissions Reduction Program. We will closely review the agency's final rule and update our members when it is issued later in the summer.

Meaningful Use of Health Information Technology

CMS issued two proposed rules earlier this year that would change Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (meaningful use). This year is a key transition year for hospitals, as it is the last year in which a hospital may begin participating to receive meaningful use incentive payments and the first year of penalties for failure to participate. CMS' first rule dealt with stage 3 proposals of the meaningful use program. Stage 3, the program's final stage, would be mandatory for all providers beginning in 2018. The proposals include many of the same measures in stage 2, but with more stringent requirements, such as higher percentage thresholds. In its comments, America's Essential Hospitals urged the agency to tailor the meaningful use program to be less burdensome on providers, particularly with regard to measures that depend on patient action.

In a rule issued in April, CMS proposed modifications to the meaningful use program for 2015 through 2017. These proposals included requiring all providers to report on a calendar year (CY) schedule beginning with the 2015 reporting period; changing the 2015 reporting period to 90 days to account for this transition to CY; and requiring most providers to attest to a uniform list of meaningful use objectives and measures beginning in 2015. The rule also included some positive changes to measures that are particularly challenging for providers, such as easing requirements for patient access to health information. We are encouraged that CMS supports a 90-day reporting period for providers and the revised patient access measure.

Extending Mental Health Parity to Medicaid Managed Care and CHIP

CMS released proposed regulations in April that applied provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to Medicaid managed care organizations (MCOs), the Children's Health Insurance Program (CHIP), and Medicaid alternative benefit plans (ABPs). The act requires plans to provide comprehensive mental health and substance use disorder benefits on par with medical and surgical benefits. The parity requirements have been extended to MCOs, CHIP, and ABPs through subregulatory guidance in previous years. However, these

parity requirements have yet to be extended to fee-for-service Medicaid enrollees and CHIP enrollees covered by the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

We are pleased CMS took this important step to protect access to mental health and substance use disorder services. We submitted comments to CMS, urging the agency to provide robust guidance and oversight to states as they work to comply with the requirements and intent of the MHPAEA, and to extend parity across all Medicaid and CHIP delivery systems. We will watch for final regulations and will continue to monitor this issue.



DATE June 12, 2015
TO Board of Directors
FROM David Engler, PhD. MS, Senior Vice President of Leadership and Innovation
RE Institute Director's Report

MEMORANDUM

Since the March 2015 board meeting, Essential Hospitals Institute completed the following work:

- As part of our work in the area of social determinants of health, the Institute is supporting member hospitals as they address the medical needs and social issues of homeless populations. In May 2015, the Institute held a webinar on how essential providers can partner with local organizations to create a comprehensive network for homeless patients. The Institute will soon publish a first-ever Quality Brief on the role essential hospitals play in health care for the homeless.
- The National Partnership hosted an in-person cross-community summit in Washington, DC on April 13 with members from the four community partners. The new partnership website, www.safetynetpartnership.org, was launched during the event, which featured best practice sharing and discussions on future policy and health care issues affecting providers filling a safety net role.
- This year's Innovations Summit will be held on October 22 and will focus on behavioral health integration. The meeting will feature essential hospitals members' work in this area. Staff is developing a research brief on innovative practices across five member hospitals for integrating behavioral health and primary care at essential hospitals. The brief will be released at the meeting. A webinar on this topic, featuring the work of Santa Clara Valley Health and Hospital System was presented to the membership on May 21.
- The research committee convened to discuss the Institute's future work around equity. The committee's discussions and recommendations will be presented at the June 24 board meeting.
- Our new class of 39 fellows will begin their first session during the week of VITAL2015.
- Program development is underway for the pilot class of the Essential Women's Leadership Academy. An advisory group of Institute board members has developed the curriculum and mentorship components of the program. The pilot class of 6 to 10 women

executives is scheduled to start in the fourth quarter of 2015. Funding requests have been sent to six foundations.

- To maintain the current Essential Hospitals Engagement Network (EHEN), staff held an “EHEN Readiness” webinar, with 46 participants on the call. Plans for the new contract – including new committees and new performance improvement efforts around C-Diff and Sepsis – were featured. More than 75 percent of the network has recommitted to another year. We await a decision on renewal by the Centers for Medicare & Medicaid Services (CMS).
- Work on the Ask Every Patient race, ethnicity, and language (REAL) project continues at a brisk pace. Five member hospitals have uploaded the e-learning module to their learning management systems. Outreach efforts to spread the module to more members are underway.
- The Patient Experience Forum, a four-part webinar series, kicked off on May 21 with 81 participants. Scheduled to run through November, the theme of the series is “sharing successful strategies to improve patient experience of care.”
- The Institute submitted a \$1.4-million, two-year proposal titled, “Accelerating Change in Essential Communities,” to the Robert Wood Johnson Foundation. The proposal envisions a comprehensive learning collaborative of safety net and non-safety net providers to accelerate reform implementation strategies. An advisory committee would oversee a re-granting component of this effort. The Institute partnered with Discern Health on key aspects of the work.
- The Institute is preparing for the launch of the 2014 Annual Hospital Characteristics Survey, which this year expands the data collection to include specialty hospitals within our membership. A robust orientation program has been developed, and a recruitment video has been filmed. Live and recorded webinar training sessions are planned for survey coordinators in addition to weekly office hours for questions and feedback.
- A half-page ad was published in *NewsPro*, a magazine for news professionals, to publicize Essential Hospitals Vital Data as the “go-to” source of data on Medicaid, social and economic barriers to care, and other issues affecting vulnerable patients.
- In May, research findings from the landscape review on population health in essential hospitals and academic medical centers were submitted for publication in the *Journal for HealthCare Quality*. The article, titled, “Advancing a Culture of Health: Population Health Programs in place at Essential Hospitals and Academic Medical Centers,” is a joint effort between the University Health Consortium (UHC), George Mason University, and the Institute.
- The Leadership Summit on State Medicaid Waivers will be held in Chicago on September 21. This second annual event will feature two tracks of programming for newcomers and seasoned waiver participants. CMS Director Wachino will be the keynote speaker.

Research Activities

Population Health Landscape Review

The Institute recently completed an ongoing initiative with partners at UHC and George Mason University. This effort included a large-scale evaluation of population health initiatives around the country based on an analysis of 121 hospital-led programs, sampled from submissions to America's Essential Hospitals Gage Awards and UHC poster presentations from 2012 to 2014. The project team analyzed this information and developed a conceptual framework for population health, particularly as it applies to essential hospitals and academic medical centers. Additionally, two webinars and stakeholder interviews were held to inform the analysis results and disseminate information to members. All findings were summarized in a scientific article, which was submitted for peer review in May 2015.

Social Determinants of Health

In January, the Institute concluded a web series on the social determinants of health. The seven monthly web postings started in July 2014 and included an overview of the social determinants of health; topic pieces on social capital, food insecurity, housing and employment, neighborhoods and safety, and education; and a wrap-up piece discussing how these issues interconnect.

In addition to highlighting the importance of patients' social factors in medical care, the series showcased the innovative practices essential hospitals use in response to social determinants of health. The series featured these member hospitals:

- Boston Medical Center
- Santa Clara Valley Medical Center
- Harborview Medical Center
- Hennepin County Medical Center
- Bon Secours Baltimore Health System
- Health Care District of Palm Beach County
- Arrowhead Regional Medical Center
- Denver Health
- Contra Costa Health Services
- Henry Ford Health System

In April 2015, the Institute conducted a webinar for its members, focusing on the relationship between homelessness, housing, and health – and why these considerations are important for health care providers. Speakers discussed how essential hospitals can improve care for homeless patients and break down traditional care siloes, including providing tips for essential hospitals to partner with local homelessness services. Speakers for this webinar included:

- Peggy Bailey – senior policy advisor, Corporation for Supportive Housing; and
- Barbara DiPietro, PhD – director of policy, National Health Care for the Homeless Council.

Transforming Care Delivery in America's Safety Net: Aligning Efforts to Improve Access and Care Coordination (Partners: The George Washington University [GWU] and National Association of Community Health Centers, Inc. [NACHC])

Into its third year, the National Partnership has worked with each of its four partner communities to build and inform collaboration with key stakeholders, develop a strategic plan, and provide technical assistance. In addition, each partner community developed a comprehensive work plan to maintain momentum and accomplish goals.

In April 2015, the National Partnership launched a website (www.safetynetpartnership.org) that contains information about all Partnership and community activities as well as key resources on effective collaborations, Medicaid waivers, and other topics of relevance to our efforts.

On April 13, 2015, the National Partnership held an in-person, cross-community summit with members from all partner communities. The goals of the conference follow:

- Provide a networking opportunity for members of the National Partnership communities
- Discuss best practices and identify opportunities for further collaboration between federally qualified health centers (FQHCs) and hospitals
- Examine current and future policy and health care issues that affect providers filling a safety net role (e.g., Section 1115 waivers, Medicaid expansion, payment reforms)

The event was a tremendous success, including rich discussions and insights from all participants. Our funder from Kaiser Permanente, Cecilia Escheverria, was also involved in the summit and found it to be an engaging event.

In addition to these activities, the National Partnership has focused on sustainability and phase II of this project for the past three months. The National Partnership has gleaned a substantial amount of information from phase I on the scope, feasibility, and impact of activities. The group is now prepared to implement these learnings in phase II of this effort. Some of the key differences in the proposed model for phase II follow:

- Expanding the number of communities addressed from four to eight and implementing a systematic application and evaluation process for selecting the communities
- Focusing on two key areas of interest – readiness for value-based care and Medicaid innovations
- Developing a learning collaborative on specific topics of interest, driven by aggregate demand from communities, rather than providing individualized technical assistance

A concept paper is being developed for submission to our current funders at Kaiser Permanente. Phase II will go into effect in April 2016.

Effectiveness of Transitional Care

Project ACHIEVE (Achieving Patient-Centered Care and Optimized Health in Care Transitions by Evaluating the Value of Evidence), a three-year effort funded by the Patient-Centered Outcomes Research Institute (PCORI), focuses on the following objectives:

- Learn which transitional care outcomes matter most to patients
- Evaluate current efforts to improve care transitions

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- Develop recommendations on best practices for patient-centered care transition interventions with guidance for scalability and large-scale dissemination

While this project includes a variety of partners and activities, our role centers around recruiting five to eight member hospitals to be involved in year two of this effort. Year two will focus on implementation efforts to further evaluate the effectiveness of care transition programs. This work will include retrospective and longitudinal comparative analyses of patient and caregiver experiences with specific transitional care components.

Since March 2015, our team has developed a draft recruitment plan for our member hospitals. Recruitment will begin during the summer of 2015.

Behavioral Health Integration and Primary Care Research

The research team is developing a research brief on innovative methods for integrating behavioral health and primary care at essential hospitals. This brief will focus on conducting an environmental scan of all innovative programs that have been implemented at essential hospitals on behavioral health and primary care integration. Based on this landscape review, the team will identify and describe the top five, exemplary programs across the United States.

This study is primarily qualitative, focused on understanding the design, development, and implementation of each exemplary program. In some cases, essential hospitals have gathered data on the impact of their innovative programs, which the Institute will analyze to better assess their effectiveness in addressing such elements as:

- poor care coordination and/or transition of vulnerable patients between physical and mental health care settings;
- avoidable hospitalizations;
- emergency department admissions; and
- readmission rates.

Through an initial scan of Gage Award submissions, peer-reviewed and gray literature, and health system/hospital websites, the team has identified exemplary integration practices at the following five member hospitals:

- Harris Health System
- NuHealth
- Santa Clara Valley Health & Hospital System
- UMass Memorial Health Care
- University of Texas Medical Branch

Disparities Research

The team is currently developing a topic for a research brief on equity/disparity issues within essential hospitals. On May 26, 2015, we gathered insights from the Institute's board research committee regarding appropriate research questions to pursue for this brief. The committee Chair, Dr. Leon Haley, will provide an update on these activities during the June board meeting. Our goals for this effort follow:

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- Understand how our members work to address potential inequities
 - Identify which interventions are most effective in addressing inequities and disparities among essential hospitals

We strive to reach these goals in order to affect policy change and ensure that all patients – regardless of race/ethnicity, socioeconomic status, etc. – are afforded the opportunity to receive high quality health care.

Analytics Update

The Institute is preparing to launch the fiscal year (FY) 2014 Annual Hospital Characteristics Survey, a key data source for *Essential Hospitals Vital Data*. There will be exciting changes in the FY 2014 survey. First, we will expand the survey to all hospitals within the association's membership, including specialty hospitals. Due to the significant increase in expected survey responses, we will launch a more robust orientation, training, and communications strategy, which will include the following elements:

- A recently recorded participation recruitment video targeting member CEOs to encourage their organization's participation
- Orientations with all new members to introduce them to the survey
- A live and recorded webinar training session for hospital survey coordinators who complete the survey
- A user group on the association website to give survey coordinators access to documents, a survey coordinator message board, and frequently asked questions
- Weekly office hours to give survey coordinators an opportunity to raise issues and ask questions

We have also adjusted the survey timeline and format in response to feedback from our survey coordinator satisfaction and feedback survey conducted in November. Responses indicated a desire for a later launch and deadline date. As such, the survey will now launch June 31, and the deadline will be October 31. Additionally, there was an almost 50-50 split among survey coordinators requesting that the format of the survey be in Excel or an Adobe Acrobat (pdf) fillable form. As such, we will now offer the survey in both formats, and survey coordinators can choose the option that works best for them.

In addition to work related to the Annual Hospital Characteristics Survey, analytics staff are preparing a research brief that will examine financial, utilization, and patient demographic trends of a matched set of member hospitals. The trend brief will include the past five years of characteristics and American Hospital Association data. Validation of data points is currently in progress, and the report is expected to be published in the fall.

Fellows Program

The third and final session of the 2014 Fellows Program was a culmination of the fellows' hard work and dedication. Fellows attended the association's semiannual Policy Assembly and met with their congressional delegations to advocate on behalf of essential hospitals. In addition, each fellow presented their projects and shared leadership challenges, lessons learned, and successes.

This work enforced the adaptive leadership framework, as each fellow incorporated the model in their presentations. A graduation ceremony and celebration was held in honor of the 32 fellows who completed the program. Evaluation results confirmed the success of the program, as it received an overall rating of 4.7 – the highest rating in the history of the program.

During session I of the 2015 Fellows Program, the new class will learn the overall adaptive leadership framework, developed by Harvard University's Ron Heifetz and Marty Linksy. They will begin to think about and discuss their organization's challenges, which will be the focus of their projects. The fellows will gain valuable feedback on their projects during peer-to-peer consulting sessions.

Essential Hospitals Women's Leadership Academy

The Essential Hospitals Women's Leadership Academy program development is in full swing. The advisory committee has met by telephone to design the details of the program timeline and the mentor/mentee recruitment and matching strategy. An announcement will be made at both the association and Institute board meetings to solicit mentee/mentor nominations from board members.

Performance Improvement

EHEN

The initial hospital engagement network (HEN) contract with the Partnership for Patients and CMS ended December 8, 2014. The announcement for an additional year of funding was released February 12, and we submitted a proposal on March 30, 2015. More than 75 percent of the original network has recommitted to participating in HEN 2.0. However, as yet, CMS has not made formal announcements about funding. We are optimistic about the proposal's success, given EHEN's leading role in health equity and the high evaluation marks EHEN received in August 2014.

Staff continues to support the EHEN network in their endeavors to reduce patient harm, reduce disparities, and improve patient and family engagement. Staff also provides feedback and reports to the network based on data submitted to the National Healthcare Safety Network and directly to the Institute. We have developed new reports stratified by race, ethnicity, age, and gender.

Health Equity

The Institute is involved in multiple efforts focusing on health equity, including work in performance improvement and research.

The Office of the Assistant Secretary (OASH) Office of Disease Prevention and Health Promotion (ODPHP) currently focuses on efforts to eliminate preventable adverse drug events (ADEs) and to reduce disparities in health care associated infections and readmissions. As part of this work, ODPHP engaged the MITRE Corporation to work with hospital engagement networks in a root-cause analysis to help the hospitals identify contributing factors to disparities related to ADEs. There is no additional federal funding; however, project results will be shared with all participating hospitals and health systems. The Institute is working with MITRE and EHEN 1.0

hospitals to explore participation in this partnership, as ADEs and disparities remain a focus of HEN 2.0.

Work on the Ask Every Patient: REAL project continues. This tool, launched last fall, teaches registration staff and others how to collect patients' race, ethnicity, and language data in a culturally sensitive and effective way. The module dovetails with our Equity of Care coalition work. We are building on momentum to date, including use by members Arrowhead Regional Medical Center, Cook County Health & Hospitals System, Henry Ford Health System, Regional One Health, and University Health System. Staff has developed a marketing plan to reach out to all members and leadership to encourage adoption of the e-learning module.

The Institute continues to work with its consultant to make the module available to all members and to explore ways to market it widely to all hospitals in partnership with The Joint Commission.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Our four-part webinar series, Patient Experience Forum, kicked off on May 21 with a successful inaugural entry – including 64 participants on the web plus an additional 17 on the phone or in a room with a registered participant (81 in total), representing approximately 38 member organizations. The series concludes in November 2015. Member hospitals will share successful strategies and practices to improve patient experiences, as supported by Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data. This 2015 series will be open to all members. Remaining offerings include the following:

- Applying Technology, Team Approaches to Enhance Patient Experience | The Ohio State University Wexner Medical Center and Ben Taub Hospital | July 29
- Improving Patient-Perceived Nurse Communication | Grady Health System | September 30
- Addressing Processes, Culture to Boost Patient Experience | Norwegian American Hospital and the University of Alabama at Birmingham (UAB) Hospital | November 18

Robert Wood Johnson Foundation (RWJF) Accelerating Payment and Delivery System Reform Efforts

On April 13, 2015 the Institute submitted a proposal titled, “Accelerating Change in Essential Communities (ACEC),” to RWJF to accelerate payment and delivery system reform. RWJF will conduct site visits to finalists in June, with an anticipated award announcement at the end of July. If successful, the project would start in October and last for two years.

ACEC will convene and support a comprehensive learning collaborative comprising safety net and non-safety net providers who represent a range of reform implementation efforts. This collaborative includes providers with demonstrated success, who will serve in mentorship and advisory roles; those who wish to further develop their models and share lessons learned; and five safety net providers suited for reform but lacking in adequate resources, who will receive re-granted funds. Key elements of success will be disseminated to a national audience through a public website, social media campaign, and formal reports.

The Institute proposes to partner with Discern Health for the ACEC project and will convene an advisory group of essential hospitals and stakeholders from various academic centers and provider/payer communities to guide the progress of the participants.

Transforming Clinical Practices Initiatives (TCPI)

TCPI is a new project that receives support from CMS. The initiative is designed to assist 150,000 clinician practices during the next four years to achieve large-scale health transformation.

TCPI is awarding two types of cooperative agreements: Practice Transformation Network (PTN) and Support and Alignment Network (SAN). The PTNs are learning networks of clinical practices applying best practices for positive change. The SANs provide resources and education that support workforce development among the PTNs. SANs will also help practices serving small, rural, and medically underserved communities.

The Institute submitted a proposal to serve as prime contractor for SAN and as subcontractor under UHC's proposal for a PTN. The awards were to be announced in early May; however, in early May CMS revised the anticipated announcement date to "late spring/early summer". If the Institute wins a TCPI-SAN award, it likely will add two new staff members. If UHC secures an award, existing staff would handle the Institute's subcontracted work.

Data Collection and UHC Subcontract

In December 2014 the EHEN subcontract with UHC to collect and analyze data required by the hospital engagement contract ended. We plan to renew that partnership for work under the next year of funding.