Board of Directors Meeting
501 Comfort Place, Conference Room A, Mishawaka
February 19, 2014
7:30 a.m.

BOARD BRIEFING BOOK

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Center for Hospice Care
choices to make the most of life

CHAPTER ONE

AGENDA

BOARD OF DIRECTORS MEETING
Administrative and Foundation Offices
501 Comfort Place, Room A, Mishawaka IN
February 19, 2014
7:30 a.m.

A G E N D A

1. Welcome and Introduction of New Board Members – Corey Cressy (5 minutes)

2. Approval of December 18, 2013 Minutes *(action)* – Corey Cressy (2 minutes)

3. President's Report *(information)* - Mark Murray (8 minutes)

4. Finance Committee *(action)* – Wendell Walsh (10 minutes)
   (a) December Financial Statements

5. Foundation Update *(information)* – Terry Rodino (15 minutes)

6. Board Education *(information)* – "2013: The Year in Review" – Mark Murray (15 minutes)

7. Chairman's Report *(information)* – Corey Cressy (5 minutes)

Next meeting April 16, 2014 at 7:30 a.m.

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Center for Hospice Care
choices to make the most of life

CHAPTER TWO

MINUTES

Center for Hospice Care
Board of Directors Meeting Minutes
December 18, 2013

Members Present:	Amy Kuhar Mauro, Becky Asleson, Carmi Murphy, Corey Cressy, Jim Brotherson, Julie Englert, Mary Newbold, Terry Rodino, Tim Yoder, Wendell Walsh
Absent:	Francis Ellert, Michael Method
CHC Staff:	Mark Murray, Amy Tribbett, Dave Haley, Donna Tieman, Karl Holderman, Mike Wargo, Becky Kizer

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 7:30 a.m.	
2. Minutes	• A motion was made to accept the minutes of the 10/18/13 meeting as presented. The motion was accepted unanimously.	W. Walsh motioned T. Yoder seconded
3. President's Report	• Average daily census is holding steady at 329-330. January 2013 it was 305. YTD patients served are up 7%, and we are forecasting serving our 2,000th patient this year. New admissions are up 11%. The ALOS for deaths is down to 60 days from 68 days a year ago. The median LOS is 12 days compared to 19 days last year for a program intended for up to six months. Nationally hospices are seeing the same lower median LOS. The NHPCO Facts and Figures report in the board packet has further details. • We continue to ramp up our palliative care program. The CEO of Elkhart General Hospital announced to their medical staff that CHC Medical Director, Amber Burger, MD is now their Director of Palliative Care at that hospital. She will be there about ten hours a week to do palliative care consults. Hopefully we will benefit by finding patients earlier. EGH will pay us for her services and we can bill Medicare Part B for the consults and retain that revenue. We continue to get a lot of interest in palliative care from local hospitals and nursing homes. • The annual memorial service was held 12/01. 720 family members participated at three concurrent locations in Plymouth, South Bend and Elkhart, which is about 100 more than last year. 72 staff and volunteers participated. Every person that RSVP'd received an ornament with their loved one's name on it. It was a tremendous success and another thing that separates us from our competition. • The Quality Improvement (QI) Committee meets quarterly to review hospice and home health records. One area that is audited is whether the nurse is assessing what the patient rates their pain on every visit. It is not a requirement for licensure	

Topic	Discussion	Action
	or federal. It is probably happening every visit, but it is not being documented correctly in the computer. So IT has customized the Cerner software so nurses can no longer finish their visit until that area is completed in the electronic medical record We continue to work on this; however every time Cerner does an update or upgrade, we have to reinstall that piece. • The employee portion of the group health insurance premiums will remain the same in 2014. No increase for staff. Thank you to CHC Human Resources and Finance for realizing several years ago, and implementing the Health Savings Accounts, so we could be grandfathered in as a self-insured entity. • Medicaid Integrity Audit – We had two nurses from Maryland and two auditors from a CPA firm from Indianapolis come for two days to review records on 13 patients from 2008-2012. We had to have 68 bankers boxes delivered from off-site storage. They have 120 days to let us know what they found. • Policies – We will be asking the board to approve policies per licensure requirements that the governing body be involved in any clinical policies. The policies are reviewed by the administrative team and interdisciplinary team. Explanations for the changes are in the president's report. The revisions reflect changes in procedures or regulations. • A copy of the Compliance Committee minutes from their most recent meeting is included in the board packet as a requirement of our auditors. • Nominations – Thank you to our nominating committee for recruiting the new board members. The committee started meeting in July. It was a good process this year. With the change in the Bylaws and changing board terms to a calendar year, the whole process was moved up four months. Thank you to Corey C. and the nominating committee for finding extremely qualified new members. • Mishawaka Campus – Occasionally the facility is being used by people and organizations in the community with a connection to CHC. We are not seeking groups to meet here, but sometimes it makes sense and is good for us in getting the word out. With the new space we are now able to do internal things for staff that we were not able to do before without renting space. We held a "Donuts with Santa" on 12/07 for staff and their families, and over 100 people attended. Pictures with Santa, crafts, and a cookie walk were features for staff children and grandchildren. • Hospice Industry Update – Hospices are facing ongoing challenges. The face-to-	

Topic	Discussion	Action
	face visits continue to be an issue. We average 67-72 every month, and the physician also has to write a narrative on why the patient is still eligible for the Hospice Medicare Benefit at every certification. We are now required to put multiple diagnoses on the claim. ICD-9 diagnosis codes are changing to ICD-10, with 67,000 new codes to deal with. CMS said hospices could no longer use Debility or Adult Failure to Thrive as primary diagnosis codes, which were 14% of all hospices claims. So we have to find something else. We continue to deal with ongoing rate cuts since 2009, and the 2% sequestration that hit in April 2013 for all Medicare providers. Additional quality reporting requirements are coming up, with no additional reimbursement to fund the massive additional data collection mandates. The new Hospice Item Set (HIS) starts July 1, 2014—standard data collection on every hospice admission and discharge. We will also have to start reporting additional discipline visits in 15 minute increments, and every medication a patient on with the national drug code number and each facility's NPI number by line on each claim. We are working on this with our pharmacy vendor. The proposed future payment reform of the U-shaped curve was recommended as a disincentive to long LOS. CMS would pay more at the beginning and end of care and less during the middle. Not-for-profit programs like ours will make about 11% more money with this reform. About 60% of hospices are for-profits compared to 20% about 20 years ago. • Medicare D – CMS was saying hospices have to pay for all pain medications regardless of whether it related to the terminal illness or not. They are taking money back from pharmacies and telling them to collect it from the hospices. CMS said it went into effect in 2011. NHPCO is meeting with CMS on this. • NHPCO Economic Impact Survey – 2013 is included in the board packet. They did a national survey of CEOs from hospice programs, primarily not-for-profits. 75% predict increased caseloads instead of hiring more staff, 50% have consolidated clinical positions, half will have modified salary increases, two-thirds are cutting their education budget, 18% seeing a change in ownership within two years or are interested in selling, and 13% may be out of business in five years. Mark receives emails weekly about whether we are interested in selling. He asked the Executive Committee if they wanted to see these emails and they said no. Things are good at CHC compared to the rest of the industry. A 13% closure of hospices in our service area would not be a problem for us. We have about 28	

Topic	Discussion	Action
	competitors, but many of them we never see. The ADC at most hospices in the country is 60. Some have no electronic medical record—they won't survive. • 2013 was a fairly good year for us. It was a very challenging year with a huge number of distractions. Care at the bedside remains our primary focus. If the patient seems stable where their eligibility may be in question, we will contact the attending physician to see if there is anything else going on that we may not have seen. Generally we have not discharged a lot of patients because of the face-to-face visits. CMS started this to discourage long LOS, when in fact the face-to-fact visits are actually validating the LOS. • Jim B. asked with the increased burden of data collection and analysis of data required by various agencies, it ultimately bleeds resources from our services to the patient. How can board members help with this? Mark M. said there is a lot of frustration. The overall reason is Medicare is quickly running out of money. It is happening with every Medicare provider, not just hospices. Hospice's goal was always to be part of mainstream health care and now we are, so we are suffering like the others. The Board needs to continue to be supportive of the administrative team and be good ambassadors of our name and brand. We can make it up in volume. We will continue to do what is right for patients. Keep the long view and we will be around for a long time. We try to explain this to staff too so they won't panic. There are only so many people that will die that will choose hospice, so the more that number is divided among our competitors, the more difficult it will be for us. The future will be in market share shift, which is what our marketing efforts all about. We educate the general public to make decision for themselves and not what the nursing home or hospital says. We are a legacy provider that will be around a long time. It is a delicate balance between being a $22 million business and also a charity and also provide highly regulated but needed healthcare services dedicated to matters of life and death. • Looking at ways to do more with less. We have done a tremendous job squeezing expenses. Signing the new per diem contract with a DME vendor will save us about $100,000 a year. Our non-formulary drug costs have dropped from over $2.00 to about $0.18 per patient day in the last few years. Cost savings have been implemented without affecting patient care, staffing, benefits, or salaries. The fact that we are not paying rent for the former Mishawaka offices is saving $300,000 a year. Explain that to people when they ask about the new building on the river. It	

Topic	Discussion	Action
	was the least expensive location for us and made financial sense and good stewardship. Most important thing the board can do is spread the message. • Referral App –We are still meeting with doctor offices and it is another thing that sets us apart. Amy spoke with her colleagues in Las Vegas that initially rolled the App out and they said it took a while for it to take off. Mary N. did a wonderful job promoting the App. Doctors are beginning to look at technology more seriously.	
4. Finance Committee	• The committee met last week to review the October and November financial statements. October operating income was $1.5 million, total revenue $1.9 million, total expenses $1.4 million, net gain $444,260, without beneficial interest in Foundation net gain $75,285. YTD October operating income was $14.6 million, total revenue $16.2 million, total expenses $13.9 million, net gain $2.2 million, without beneficial interest in Foundation net gain $790,048. • November operating income was $1.4 million, total revenue $1.5 million, total expenses $1.3 million, net gain $185,407, without beneficial interest in Foundation net gain $23,561. YTD November operating income $16 million, total revenue $17.8 million, total expenses $15.3 million, net gain $2.4 million, without beneficial interest in Foundation net gain $813,609. • Income statement summary is on page 3, and it shows the YTD Actual and YTD Budget. The variance is $718,000 less than budgeted. The ADC is very important to the organization. A year ago at this time we had expectations of a much higher ADC for 2013, but as it played out it has been less than anticipated, even though it was a realistic expectation. Even with many more patients, the lower ADC is entirely due to late referrals and shorter lengths of stay. This is why it is important to make efforts to coach patients and families to seek our services earlier on their own. Anytime we can get people to think about hospice earlier in the process the better. That is how we compare actual to budget, so when we review the 2014 budget, we will talk about projections of ADC. • A motion was made to accept the October and November financial statements as presented. The motion was accepted unanimously. • 2014 Budget – The ADC drives everything, because we are a per diem agency. In 2013 we projected an ADC of 345, but it will come in at about 322. For 2014 we will reduce that by 3.3% to an ADC of 333. Those projections roll through the projected revenue and expenses, which are pretty much in line percentage-wise	J. Brotherson motioned C. Murphy seconded

Topic	Discussion	Action
	with what we have done historically. We are projecting operating revenue $17.8 million, total revenue $19 million, and total expenses $17.4 million. The biggest piece of expenses is always salary and wages. We do have a modest increase averaging 2% built into the budget for staff increases. The per diem contract with a DME vendor should reduce Direct Care Costs. Everything else is pretty much the same going forward. Anticipated building costs for the Mishawaka campus are based on the past few months and what we experience at all our facilities. Projecting a net gain of $1.6 million, without beneficial interest in Foundation net gain $559,000. Budgeting for about $575,000 in capital expenses, mostly related to IT infrastructure. The projections are conservative and based on the continuation of the 2% sequestration being in place for the entire year calendar year. • A motion was made to approve the 2014 budget as presented. The motion was accepted unanimously. • Flex Spending Account – This is a benefit offered as an option to staff not enrolled in our group health insurance. Federal regulation allows staff to designate tax free money from payroll for prescription medical expenses. The limit is set internally. Historically we have kept it at $2,000. About 20-25 staff participated. A motion was made to keep the Flex Spending Account limit at $2,000 for 2014. The motion was accepted unanimously.	J. Englert motioned T. Rodino seconded J. Brotherson motioned T. Yoder seconded
5. QI Committee Report	• Mark reported on some of this in his President's Report (see #3 above). If something is not documented, it didn't happen. Pain is assessed on a 0-10 pain scale. People with chronic pain may say they feel fine, but then rate it a 9. It is not an issue of quality of care; staff is just not checking the right boxes in the computer. We have implement some disciplinary actions and done a lot of education with staff. • Documenting the reason a patient was on an antibiotic decreased from 100% to 75%. The FEHC (Family Evaluation of Hospice Care) survey top three areas for improvement were: (1) Confidence doing what was needed to care for patient, (2) Confidence in expectations while patient was dying, and (3) Quality of care improved after hospice was involved. We continue to do better than the average in Indiana and nationally for right amount of religious or spiritual contact, and emotional support to the family prior and after the patient's death. We applaud the nurses on quality of care. Just need to check the right boxes.	

Topic	Discussion	Action
6. Policies	• The following new and revised policies were reviewed. We continually review policies and procedures to stay abreast of regulatory requirements and changes in practices. • Availability 24/7 – Not required by any regulation, but spells out our service promises and how we care for patients 24/7. • Dating of Medical Records – Regulatory requirement. Revised to include more direction as it relates to medical records. • ECF Services Provided to a Hospice Patient – Indiana regulation. Created process several years ago. • Elder Justice Act Reporting – Staff attended a conference earlier this year that gave some revisions to the Act, so the policy was revised to reflect those changes to the law. • Infection Control Program – Regulatory requirement that hospices have a program to track any patient infections or communicable diseases. • Plan of Care Coordination – Revised to take out some verbiage that didn't need to be in there. • Standards of Care – Removed hospice language from a home health care policy. • A motion was made to accept the new and revised policies as presented. The motion was accepted unanimously.	W. Walsh motioned M. Newbold seconded
7. Foundation Update	• See President's Report on pages 5-8. Fundraising is trending about 5% ahead of a year ago. $975,000 in total fundraising less bequests and other capital campaign gifts. • The Second Annual Okuyamba Fest was attended by 62 people and raised $4,000. The money goes towards defraying costs of PCAU's new building. Through payroll deduction, employee giving to the Uganda Impact Fund and We Believe Fund is tracking ahead of last year. We are happy staff is embracing these important programs we are involved with. • A copy of PCAU's Five-Year Partnership Report is included in the board packet. This is our 5th anniversary partnering with them, and it is amazing to see the impact we have been able to make in Uganda. 69 districts are now benefiting from palliative care in part to the work we have done with them. Rose Kiwanuka will be here in the spring. She said to tell the board thank you so much for your support. • A copy of the Road to Hope brochure is in the board packet. It was designed in-house by Jim Wiskotoni. This fund was developed by PCAU in conjunction with	

Topic	Discussion	Action
	the Hospice Foundation to help children that were caregivers. Often there are no bereavement services or follow-up after a patient dies, so the Road to Hope will provide bereavement and take care of these children, help families, etc. 16 children are in the program today. A group in California has embraced this concept and is putting together a fundraising event tentatively scheduled for April with a goal to net $100,000. Mike met with them last week. • Notre Dame Film School graduates Collin Erker and Marty Flavin, are gone now, but helped us develop a number of projects in-house that we would normally have had to outsource or not do. They created an internship video to raise awareness of opportunities available for Notre Dame, Saint Mary's, and Holy Cross students in Uganda and with CHC, began shooting video for our comprehensive fundraising campaign, created PSA spots for the Walk and Bike events and audio versions for radio. • The Friends of Hospice campaign exceeded its goal of $45,000. The goal for the Annual Appeal is $100,000.	
8. Election of Board Members	• Biographical sketches of the four proposed new board members are in the board packet: Anna Milligan, Suzanne Morgan, Tim Portolese and Carol Walker. The executive committee recommends approval for these nominees. A motion was made to accept the list of nominees as presented. The motion was accepted unanimously. • A motion was made to re-elect Wendell Walsh to a second three-year term on the board of directors. The motion was accepted unanimously. • The nominating committee assures the board we are always making an effort to add diversity to the board. We are finding that leaders in the African American and Hispanic communities are often already recruited by other organizations and don't have time. It should be the goal of the board to pursue this as they talk to people about the mission of CHC and get them interested, so we are not rushed at the end of the year. Develop and cultivate relationships for the future.	J. Englert motioned J. Brotherson seconded T. Rodino motioned A. Mauro seconded
9. Board Education	• Amy Tribbett and Cyndy Searfoss gave an overview of CHC and the Hospice Foundation's involvement in social media. We do analysis to reach target audiences at the best time and place. We design our message in a way that is appealing and informative at the same time. The Foundation's mission is education, collaboration, fundraising and stewardship. We try to get people excited about our events. We also have a YouTube channel and the videos from	

Topic	Discussion	Action
	the Helping Hands Award Dinners and our TV commercials are posted there. Jim Wiskotoni does all of this in-house. We can see which pages get the most traffic by audience. The Foundation staff works closely with our Marketing staff to share messages and information. We also get a lot of information through NHPCO. Our research shows most people don't know who to call about hospice, when to call, and who pays for it. Let people know we are on social media. Our business cards also list our social media addresses on the back.	
10. Chairman's Report	• Jim Brotherson was recognized and thanked for serving on the CHC board of directors.	
Adjournment	• The meeting adjourned at 8:55 a.m.	Next meeting 02/19/14

Prepared by Becky Kizer for approval by the Board of Directors on 02/19/14.

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Julie Englert, Secretary Becky Kizer, Recording Secretary

Center for Hospice Care
choices to make the most of life

CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
Hospice Foundation
President / CEO Report
February 19, 2014
(*Report posted to Board Website February 13, 2014)*

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:30 AM. This report includes event information from December 18, 2013 – February 19, 2014. The Hospice Foundation Board meeting follows in the same room.

CENSUS

For 2013, CHC had the highest annual percentage increase in patients served in the last four years. CHC cared for more patients than in any year in history with 1,993 patients, a 7% increase from 2012's 1,866 (2012 was only a 1% increase from 2011). Both Hospice Houses cared for 4% more patients than the previous year with an all-time high of 564 patients calling Hospice House a home. Overall referrals to CHC in 2013 totaled 2,717, another record number and an increase of 7.3% from 2012. Referrals from the general public continued to increase in 2013 and prove our marketing media campaign is working. Referral calls from Family, Self or Other in 2013 totaled 723 compared to 632 in 2012 and 483 in 2011. Referrals in the self-directed category are now up 50% from three years ago when we began our current media campaign. We are starting the New Year with an Average Daily Census for January 2014 that is up 5% from January 2013.

January 2014	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	463	463	479	(16)
Original Admissions	158	158	168	(10)
ADC Hospice	304.35	304.35	383.94	20.41
ADC Home Health	16.58	16.58	21.00	(4.42)
ADC CHC Total	320.93	320.93	304.94	15.99

December 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
Patients Served	429	1,993	1,866	127
Original Admissions	132	1,682	1,527	155
ADC Hospice	305.68	303.07	318.05	(14.98)
ADC Home Health	18.13	19.55	19.23	.32
ADC CHC Total	323.81	322.62	337.28	(14.66)

Monthly Average Daily Census by Office and Hospice Houses

	2014 Jan	**2014** Feb	**2014** Mar	**2014** Apr	**2014** May	**2013** June	**2013** July	**2013** Aug	**2013** Sept	**2013** Oct	**2013** Nov	**2013** Dec
S.B.:	196					175	174	189	195	198	194	201
Ply:	62					61	60	57	65	61	62	59
Elk:	53					70	70	68	66	67	66	58
SBH:	5					4	5	4	5	4	4	4
EKH:	4					4	4	3	4	3	3	2
Total:	321					314	313	321	334	333	329	324

HOSPICE HOUSES

January 2014	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
SB House Pts Served	33	33	77	(14)
SB House ALOS	5.03	5.03	3.79	1.24
SB House Occupancy	76.50%	76.50%	82.03%	-5.53%
Elk House Pts Served	24	24	12	12
Elk House ALOS	4.79	4.79	2.92	1.87
Elk House Occupancy	53.00%	53.00%	16.13%	36.87%

December 2013	**Current Month**	**Year to Date**	**Prior Year to Date**	**YTD Change**
SB House Pts Served	23	341	305	36
SB House ALOS	4.87	5.23	5.77	(0.54)
SB House Occupancy	51.61%	69.75%	68.74%	1.01%
Elk House Pts Served	22	223	237	(14)
Elk House ALOS	3.30	5.64	6.04	(0.40)
Elk House Occupancy	30.41%	49.20%	55.89%	-6.69%

PATIENTS IN FACILITIES

Of the 463 patients served in January 2014, 143 resided in facilities, and of the 429 patients served in December 2013, 157 resided in facilities. The average daily census of patients in skilled nursing homes, assisted living facilities, and group homes during January was 115; December was 122 and YTD through December 2013 was 113.

FINANCES

Karl Holderman, CFO, reports the December and year-to-date December 2013 Financials will be posted to the Board website on Friday morning, February 14th following Finance Committee approval. For information purposes, the Finance Committee approved November 2013 financials are below. As always, due to year-end closing of the calendar fiscal year books, the January and February 2014 financials will be covered at the April 2014 CHC Board Meeting.

November 2014 Financial Information

Center for Hospice Care

(Numbers include CHC's beneficial interest in the Hospice Foundation including its loss / gain)

November Overall Revenue	$	1,567,647	Year to Date Overall Revenue	$	17,806,273
November Total Expense	$	1,382,240	Year to Date Total Expense	$	15,361,955
November Net Gain	$	185,407	Year to Date Net Gain	$	2,444,318

Hospice Foundation

Novem Development Income	$	47,133	Year to Date Development Income	$	901,745
Novem Investment Gains (Loss)	$	232,884	Year to Date Investment Income	$	2,110,826
November Overall revenue	$	283,969	Year to Date Overall Revenue	$	3,119,339
Total November Expenses	$	122,123	Total Year to Date Expenses	$	1,488,630
November Net Gain	$	161,846	Year to Date Overall Net	$	1,630,709

Combined

November Overall Revenue	$	1,405,801	Year to Date Overall Revenue	$	19,294,903
November Overall Net Gain	$	185,407	Year to Date Overall Net Gain	$	2,444,318

At the end of November 2013, Center for Hospice Care's Year to Date Net without the beneficial interest in the Hospice Foundation was $813,609.

At the end of November 2013, the Foundation's Intermediate Investments totaled $4,344,770. Long Term Investments totaled $15,171,694.

CHC's assets on November 30, 2013, *including* its beneficial interest in the Hospice Foundation, totaled $33.7MM. At November 30, 2013 HF's assets alone totaled just over $29.9MM and debt

related to the low interest line of credit associated with the Mishawaka Campus project totaled just over $5.7MM.

CHC VP/COO UPDATE

Dave Haley, VP/COO, reports we recently entered into a contract with MDwise to be a provider for Select Health, a contractual arrangement related to the Affordable Care Act. We have also successfully renewed the on-going agreement with Anthem Insurance and were added by United Healthcare as a provider during 2013.

We have entered into an agreement with Alick's Home Medical Equipment whereby they are our preferred provider of durable medical equipment throughout our entire geographic service area. This agreement also switches CHC from a per piece payment rate to a per diem payment rate with them. It is anticipated that this arrangement will generate significant savings for CHC over time.

All departments are preparing for the arrival of the Hospice and Palliative Medicine Fellow from Mayo Clinic. She will arrive in Mishawaka on March 16 and complete her training on April 11. She will reside in the Guest House on the Mishawaka Campus.

During 2013 we experienced 113 deaths before admission (DBAs) which were referred by Memorial Hospital, St. Joseph Regional Medical Center, and Elkhart General Hospital. This is a ratio of 1 out of every 8.8 referrals from these hospitals. The day of the week with the highest DBA rate in 2013 was Friday. The month of the year with the highest DBA frequency was August. Individual hospital experience will be shared with each hospital. Additionally, CHC also received 41 additional referrals from these three hospitals which resulted in patients being discharged from the hospital and simultaneously admitted to hospice while physically remaining in the hospital. These were patients imminently dying and who were too fragile to be transported to Hospice House. These are patients that prior to having these agreements with our hospitals may not have experienced hospice care at all.

For the entire agency during 2013 and throughout our eight county service area, we responded to a death at a rate of one every 5.5 hours around the clock each day of the year.

Dave Haley's Census Charts are contained as an attachment to this report.

DIRECTOR OF NURSING UPDATE

Donna Tieman, RN, DON, reports the Nursing department organized the third annual CHC blood drive which was held at the Mishawaka and South Bend campuses on January 15, 2014. More than 50 people in our community will be helped by the generous staff who donated blood. Donna thanks Amy Tribbett and the marketing support she gave to the event, so we were able to get the message of giving the lifesaving gift of blood to more people.

On January 14, 2014, a representative from Community Health Alliance did site visits at both the South Bend and Elkhart Hospice Houses. The purpose of the visit was to survey our inpatient units

for re-credentialing by CHA referral sources. The surveyor, accompanied by Donna Tieman, stated she was very impressed with the appearance and cleanliness of our facilities.

Donna Tieman will be the guest speaker at the Compassionate Care in Medicine Club on the campus of Notre Dame on February 27, 2014. The club is comprised of pre-med students and is a branch from the Compassionate Care in Medicine department.

The CHC Nursing department had 78 students from three area nursing schools complete clinical rotations during the 2013 fall and 2014 spring semesters. The nursing schools represented are IUSB, Saint Mary's and Bethel.

HOSPICE FOUNDATION VP / COO UPDATE

Mike Wargo, VP/COO, Hospice Foundation (HF), reports through January 2014, the Development Department recorded the following calendar year gift totals as compared with the same period during the prior four years:

Year to Date Total Revenue (Cumulative)

	2010	2011	2012	2013	2014
January	64,964.45	32,655.69	36,775.87	83,619.96	51,685.37
February	108,025.76	64,530.43	88,893.51	166,563.17	
March	231,949.73	165,468.92	194,345.35	264,625.29	
April	354,644.69	269,676.53	319,818.81	395,299.97	
May	389,785.41	332,141.44	416,792.85	446,125.49	
June	477,029.89	427,098.62	513,432.22	534,757.61	
July	532,913.52	487,325.01	579,801.36	604,696.88	
August	585,168.77	626,466.72	643,819.01	783,993.15	
September	671,103.04	724,782.28	736,557.59	864,352.82	
October	992,743.37	1,026,728.58	846,979.95	922,261.84	
November	1,043,750.46	1,091,575.65	895,164.28	969,395.17	
December	1,178,938.91	1,275,402.38	1,027,116.05	1,185,322.83	

Year to Date Monthly Revenue

(less Elkhart Hospice House capital campaign, bequests and one-time major gifts)

	2010	2011	2012	2013	2014
January	52,442.49	32,110.69	32,309.58	83,380.18	51,685.37
February	41,364.37	30,644.74	43,783.64	82,943.21	
March	65,886.51	99,796.42	102,351.84	98,212.12	
April	104,544.96	97,332.61	123,998.46	130,674.68	
May	33,768.72	51,753.98	90,909.04	40,825.52	
June	74,084.48	90,718.18	92,036.89	65,815.51	
July	55,278.63	53,536.39	62,069.43	69,939.27	
August	51,240.25	83,202.86	64,017.65	92,732.69	
September	85,629.27	94,000.56	92,808.58	80,335.67	
October	66,061.97	47,779.09	65,904.80	56,439.02	
November	49,247.09	48,284.08	46,674.33	47,133.33	
December	115,188.45	133,617.73	111,236.77	130,277.99	
Total	**794,737.19**	**862,777.33**	**928,101.01**	**978,709.19**	**51,685.37**

Special Events and Projects

Planning is underway for 2014's major events: 30th Annual Helping Hands Award Dinner, to be held at Hilton Garden Inn on May 7; the 29th Annual Walk for Hospice, which will start from the Mishawaka Campus on August 10; and 6th Annual Bike Michiana for Hospice, slated for September 14 at St. Patrick's County Park.

This year's Helping Hands Award recipient is Elkhart philanthropist, community leader and former Godfrey Marine CEO Robert (Bob) Deputy. The honorary chair of the event will be Art Decio. Announcement post cards will be in the mail soon and invitations will be sent the second week of March.

FHSSA / Palliative Care Association of Uganda (PCAU) Partnership

For the 4th consecutive year, Roberta Spencer is once again volunteering in Uganda for six weeks to undertake a series of liaison activities with PCAU including spiritual care presentations and meetings, Road to Hope program monitoring, staff training and a series of board and outreach meetings. Her blog is available on the Foundation's web site at www.foundationforhospice.org/partnerships.

A 20-page "Five-Year Partnership Report" was published in November and has been mailed to all past and present PCAU donors and other key supporters, along with a letter thanking them for the support. A PDF has been made available to PCAU and Roberta carried hard copies of the report along with her.

Rose Kiwanuka, National Coordinator for PCAU, will be visiting CHC/HF from March 21-April 17. She will be attending NHPCO's Management and Leadership Conference during her first week in the U.S., as well as speaking at the annual FHSSA Breakfast. A number of educational and outreach activities are planned for her four-week visit including meetings with leaders of various Notre Dame internship programs, ND partners and potential partners, a presentation to Holy Cross College students and faculty, as well as meetings with CHC/HF staff. A reception will be held in her honor at the Mishawaka Campus on the evening of Wednesday, April 16.

Film Production / Road to Hope Program

Cataloged footage filmed for the *Road to Hope* film has been handed over to Ted Mandell of the Notre Dame Film, Television and Theatre department for editing. The documentary is scheduled for release in late 2014.

Thanks to a connection made by Collin Erker, who was part of the documentary film crew, we have our second elementary school, this one located in Florida, which has pledged to sponsor a Road to Hope child for one year. The Prairie Vista Elementary School Student Council, in Granger, sponsored a child last year and is planning to do so again in 2014.

Mishawaka Campus

DJ Construction has begun work to transform the former Edgewater Florist building into a Palliative Care Center. Jeff Helman and Brad Sechrist are working on conceptual designs for Phase II of our campus development. Chris Chockley is finalizing plans for completion of the campus grounds project, with work scheduled to begin in the spring.

Annual Giving

As of January 31st, the 2013 Annual Appeal has reached $72,455.19 of its ambitious $100,000 goal. This is the first Annual Appeal to feature the new "Champion" giving level, set at $25,000 in annual, cumulative donations. Through 1/31, we have had a total of 436 gifts, with an average gift of $161.77. By comparison, the 2011 Annual Appeal raised $81,090.16 with an average gift of $126.11; 2012 was $91,267.21 with an average gift of $139.98.

An e-blast was sent at the end of January reminding donors and potential donors that those giving at the Helping Hands Society level or above before January 31, 2014 would receive two complimentary tickets to this year's Helping Hands Award Dinner. We received two additional donations at this level as a result of the e-blast as well as a number of additional online donations. The Annual Appeal will continue through the month of May.

Communications

Our very first donor survey, which was rolled out in phases to donors and supporters over the past several months, continues to generate responses. All Circle of Caring members received a mailed survey. Even though the return envelope required the respondent to use their own stamp, we received an 11% response rate from the 343 mailed surveys, not including those who may have responded online. The results were very favorable with between 92% and 93% of all responders indicating they either "Agreed" or "Strongly Agreed" that they "were being kept informed of the use of CHC's funds," that they "receive the right amount of information regarding the use of (their) donation" and that they "receive the right amount of recognition for being a CHC donor." The remaining 7% to 8% indicated that they neither "Agreed nor Disagreed" with the statement and not a single responder indicated that they "Disagreed" or "Strongly Disagreed" with the statements. Approximately 25% of all responders included a comment. Among them: "You have a great organization. We will continue to support you." "We do not wish to be honored; we just want to sincerely thank you for your help & support." "All comments I hear regarding CHC are completely positive." "I just wish I could donate more." There were no negative comments made by any responder. The survey continues to be available online and has been announced via the Hospice Foundation's e-newsletter as well as in the Fall/Winter issue of *Crossroads,* which was mailed to 36,000 homes and businesses.

The spring issue of *Crossroads* is in the final phase of production and will be mailed in March. To commemorate the 40th Anniversary of Hospice in America, this edition features the first in a series of stories about the history of the hospice movement.

Third-Party Fundraising

Plans for a Hollywood celebrity event to raise money for the Road to Hope Fund are well underway. The event will be held on April 14th to coincide with Rose Kiwanuka's visit to the U.S. The fundraising group, which includes celebrities Torrey DeVitto and Brandi Milloy, hopes to net $100,000 from the event. Members of the hosting committee include a number of Torrey and Brandi's Hollywood friends and local fundraisers.

Meanwhile back in South Bend, an event featuring Bucky and the Lip Rippers will be held at the LaSalle Kitchen and Tavern on March 1, with proceeds to benefit CHC. As details are finalized they will posted on our social media pages and be included in an e-blast.

COMMUNICATIONS, MARKETING, VOLUNTEERS AND ACCESS

Amy Tribbett, Director of Marketing and Access reports...

Outreach and Liaison News in December & January

Number of Pre-Assessments	5
Number of Hospital Visits	34
Number of ECF Visits	94
Number of ALs or CCRC	35
Number of Physician Practices	87

Amy Tribbett is presenting at NHPCO's Management & Leadership Conference in March. She, along with two other marketing professionals, will present: "Hungry for Good PR? Your Recipe for a Successful PR and Media Program."

Introduction of the CHC Referral App has taken place at:

- Memorial I Street Practice Manager – La Porte
- Practice Manager for Dr. Benfit
- Hickory Creek, Rochester
- Dr. Rod Kubley
- Dr. Alrdridge
- Dr. Holm and NPs
- DC Planner Community Hospital of Bremen,
- Bremen Health Care
- Drs Kolbe and Buck
- Signature HealthCare
- Ironwood Health and Rehab
- MHO corporate offices
- Drs Fasih, Knight, Ahju, Landrum
- Dr. Rogers
- Arborwood
- Dr. Alexander
- Pilgrim Manor

Highlights of Referral Meetings, Lunches, Senior Networking and Speaking Engagements:

- Corn Dance Event with Miller's Merry Manor
- Lunch and Learn at Elkhart County Council on Aging Life Enrichment Site with 35 attendees.
- Breakfast In-service at Elkhart Clinic Internal A with 30 attendees.
- Lakeview Funeral Home and Crematory – Lakeview wanting to do joint bereavement – scheduled for April.
- Lunch at Schwartz Weicamp Family Physicians in Mishawaka/Granger.
- Lunch in-service with Dr. Siddiqui in Elkhart. He is an internist who is Medical Director at Riverside Village and Valley View Health Care.
- Michiana Hematology Oncology -- 12/12/13 corporate-level meeting pre-scheduled to discuss new referral app. Additional data compiled for years 2011 through 2013, for direct referrals/admissions from MHO, to establish base trend tracking of these data sets -- South Bend, Elkhart and Plymouth CHC data included in this data set.
- Memorial Hospital of South Bend -- to assure CHC is appropriately responsive.
- St. Joseph Regional Medical Center/Mishawaka -- 12/10/13 introductory appointment with Lou Pace, Palliative Care, yielded information regarding this institution's plans for palliative care service delivery.

WELCOME NEW CHC BOARD MEMBERS

Please join me in welcoming our new board members: Anna Milligan, Sue Morgan, Tim Portolese and Carol Walker. All four completed their new board member orientation on January 16 with a two-hour breakfast seminar presented by members of the CHC Administrative Team. A new 2014 Roster of CHC Board Members along with contact information is included as an attachment to this report.

CHC TO RECEIVE 2014 "ECONOMIC IMPACT AWARD" FROM ST. JOSEPH COUNTY CHAMBER OF COMMERCE

In late December I was informed by the CEO of the St. Joseph County Chamber of Commerce that CHC would be receiving the 2014 Economic Impact Award – one of five awards presented -- at the annual Salute to Business luncheon on February 27, 2014. CHC was selected for this award primarily due to the Phase I development of our Mishawaka Campus along the St. Joseph River. Recent previous winners of this award include Data Realty, Sprenger Healthcare, Allied Physicians of Michiana, Shafer Gear Works, Inc., Michiana Hematology-Oncology, and Saint Joseph Regional Medical Center. The Award will be accepted by CHC Volunteer Board Chair, Corey Cressy.

2013 ANNUAL GOALS UPDATE

Included in your packet is a final status copy of the 84 individual goals for 2013. Status of the goals is broken down into four categories. "Met" means that the goal was achieved. "In Process" means the goal was started, but not yet completed during calendar year 2013 and likely carried over to 2014. "Not Doing" means after evaluating the goal we decided that for whatever reason we were

not going to do the project. "Not Met" means that we simply didn't get to that goal at all. Results for 2013 are as follows:

Total Number of Published Goals = 84
Met = 52 (62%)
In Process = 28 (33%)
Not Doing = 4 (5%)
Not Met = 0 (0%)

For calendar year 2013, 95% of the 84 individual goals were either completed or are in the process of being completed at the end of the year. We are delighted to answer specific questions on any of the goals and their status at the end of the year.

GOALS 2014

Included in your packet are the 2014 Goals for Center for Hospice Care and the Hospice Foundation. We have placed individual goals under headings that match the 2011-2015 Strategic Plan. The four overarching goals are: Enhance Patient Care; Position for Future Growth; Maintain Economic Strength; and Continue Building Brand Identification. Annual Goal development begins at the Coordinator level of management and they work their way up through Directors and eventually to the Administrative Team for final approval. We always commence with what staff believes we should accomplish to improve and enhance our organization and the care we deliver to our patients and families.

2013 BEREAVEMENT STATISTICS

The Bereavement Department reports that during 2013 it had 131 average deaths per month, the highest in history. It served 2,547 new clients, up 16% from 2,190 in 2012. 16% of the new clients were from the community and without a connection to a loved one as a hospice patient, which is up from 15% in 2012. Additionally, it facilitated 360 group support meetings, performed 1,884 risk assessments, made 4,103 caring phone calls, and mailed 16,918 pieces of materials including letters, magazines and brochures offering condolences and information regarding our comprehensive grief intervention services. They produced one Memorial service at each community where we have care offices and they were attended by a record 792 people. Our Bereavement Department also produced CHC's 20th Camp Evergreen program for children who have experienced the death of a special person in their life. There were 45 campers in attendance along with 64 community volunteers. Phone calls, assessments, mailings, and individual / group counseling sessions and presentations totaled 25,649 encounters during 2013, down 3% from 2012.

NEW, ADDITIONAL AND EXPENSIVE REGULATORY MANDATES FOR 2014

The following is a brief listing of new requirements from the Centers for Medicare and Medicaid Services (CMS) for Medicare Hospice providers for this calendar year alone.

April 1, 2014 -- Additional Data Reporting Requirement (Mandatory Reporting) CMS CR 8358 requires hospice providers to include additional information on the hospice claim form. Additional data reporting includes visit reporting for general inpatient care, reporting the service facility National Provider Identifier (NPI) where the service was performed when the service is not performed at the same location as the billing hospice's location, and reporting of infusion pumps and prescription drugs.

Hospices report line-item visit data for hospice staff providing General Inpatient Care (GIP) to hospice patients in skilled nursing facilities or in hospitals for claims with dates of service on or after April 1, 2014. This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech-language pathologists, on a line-item basis, with visit and visit length to be reported in 15 minute increments. Additionally, new post-mortem visit reporting is required using appropriate visit revenue codes for the corresponding discipline in 15 minute increments along with further instructions if the visit begins and ends spanning a period involving midnight.

Prescription drug reporting includes reporting on a line-item basis per fill (based on the amount dispensed by the pharmacy); using correct revenue codes and the National Drug Code (NDC) number representing the quantity of the drug filled which shall be reported as the unit measure for each medication. This must appear on the actual hospice claim form. Hospice patients often average 32 different medications.

Reporting is required for injectable drugs on a line-item basis per fill, using the appropriate Healthcare Common Procedure Coding System (HCPCS) code with units representing the amount filled. Non-injectable prescriptions will also be reported on a line-item basis per fill (based on the amount dispensed by the pharmacy), using the NDC qualifier to represent the quantity of the drug filled and shall be reported as the unit measure.

Infusion pumps will be reported on a line-item basis per pump order and per medication refill, using the appropriate revenue codes for the equipment and for the drugs along with the appropriate HCPCS code.

After reporting all of this additional data, line by line, for all Hospice Medicare patients, CHC will still get paid about $150 per day and nothing about this additional reporting will make any difference whatsoever in the amount we are reimbursed for our services. There is also no additional payment for the expense of these ongoing data collection mandates.

April 1, 2014 -- Mandatory quality reporting: Submission of Quality Assurance Performance Improvement Structural Measure and National Quality Forum (NQF) 0209 data to CMS. (Data collection period is January 1, 2013 through December 31, 2013).

July 1, 2014 -- Hospice Item Set (HIS) implementation: CMS has developed and tested a hospice patient-level item set to be used by all hospices to collect and submit standardized data items about each patient admitted to hospice. There are 41 different data elements to collect for each patient upon admission and 11 elements at discharge. Even though this directive is from CMS, who administers the Medicare / Medicaid program, they are requiring hospice to collect data on all patients regardless of payor. To make matters even more cumbersome, all of this data must be

entered into a specific CMS designed website (the same people that brought you healthcare.gov). The standardized data collection tool will be used to collect data on seven NQF endorsed measures. Implementation is scheduled to begin July 1, 2014 and will affect federal fiscal year (FY) 2016 payment determination, meaning if a hospice doesn't do it now, their reimbursement rates will be cut even further in the future.

September 22, 2014 -- The HIPAA Omnibus Rule: For those business associate agreements that qualify for the transition exception, the parties will have until the earlier of (1) the date the existing agreement is renewed or modified, or (2) September 22, 2014, to bring their agreements into compliance.

October 1, 2014 -- Claims returned to provider (RTP): CMS (contained within the FY2014 Wage Index Final Rule) has directed that all Hospice Medicare claims that use a manifestation code as a primary diagnosis -- including the widely used debility and adult failure to thrive -- will not be paid for services provided on and after October 1, 2014. These two codes mentioned previously represented at least 12% of codes used as a primary diagnosis for the 1.6 million hospice patients in 2012. On 10/1/14 CMS will no longer pay for these diagnosis codes under Medicare Hospice at all.

October 1, 2014 -- ICD-10 implementation: (the 10th revision of the International Statistical Classification of Diseases (ICD) and Related Health Problems -- a medical classification list by the World Health Organization). The US Department of Health and Human Services (HHS) has mandated the replacement of the ICD-9-CM code sets used by medical coders and billers to report health care diagnoses and procedures with ICD-10 code sets, effective Oct. 1, 2014. The transition from ICD-9 to ICD-10 involves expanding medical diagnosis codes from the current 14,000 to more than 67,000, and procedure codes from 13,000 to 85,000. HHS hopes this move will help the industry identify more billing fraud, allow more thorough quality reporting by healthcare providers, and enable refinements in reimbursement models through more detailed diagnostic and procedure data.

Current and Ongoing – Additional cost data must now be reported on the Medicare Cost Report for hospice, which is filed annually with CMS. Significant new requirements which add new elements and expand the detail of costs across many areas are now required to be included in an updated Medicare Cost Report.

Other Items of Concern and Distraction -- There is a ploy by CMS to adopt a new policy that states in addition to the hospice paying for all medications related to the palliation and symptom management of the terminal illness, that the hospice will be financially responsible for ALL medications a hospice patient is taking and if the hospice decides any medication is *not* related to the terminal illness, and therefore not included in the hospice plan of care, the hospice will need to document the reason *why* each medication is not related to the terminal illness. This is a major reinterpretation of the federal statute going back to the mid-1980s. NHPCO continues to attempt to work with CMS on this. On a side but related note, CMS has already begun recoupment from pharmacies for reimbursement for all pain medications paid for under Medicare Part D during 2011 if Part D claims paid for the pain medication during the same time the patient was enrolled in the Medicare Hospice benefit. CMS believes that the hospice program should have covered and paid for all pain medications period. This is another dramatic reinterpretation of the original federal statute, 30+ years of historical practice, and current practice up until now. Individual pharmacies

then have to go back to the individual hospice program to seek payment for individual prescriptions filled during 2011 for patients that have long been deceased. Of course, there are many reasons why some pain medications (treatment of long-term arthritis, for example) would not be related to a terminal illness and not included in the hospice plan of care. NHPCO has been successful at convincing several Congressional Offices to write to the CMS Administrator telling them to "stop it," but recoupment continues as I write this.

2015 and Beyond – There is much more in the pipeline similar to the above, including Hospice Medicare payment reform. Section 3132(a) of the Affordable Care Act (Patient Protection and Affordable Care Act, 2010) requires the Secretary of HHS to reform Medicare's payment system for hospice care. By law this cannot happen before FY2014 and currently CMS doesn't appear interested in taking this on too right now. The biggest threat would be CMS quickly taking the easy way out and rather than go to the trouble of redesigning and testing an entirely new payment methodology, they simply rebase the current system. Estimates are that this could lower hospice per diem reimbursement by somewhere in the neighborhood of $10.00 per day.

CHC NOW HAS ACCESS TO ALL MATERIAL FROM THE ADVISORY BOARD COMPANY

Thanks to a deal negotiated by the National Hospice Executive Roundtable (NHERT) CEOs, the NHERT and their hospice programs are now members of the Advisory Board Company (ABC) and have access to all ABC materials and research along with the 30-year archive of material at the ABC website. NHERT members also have their own ABC dedicated advisor. The ABC is a global research, technology, consulting and performance improvement partner for 165,000+ leaders in 4,100+ organizations across health care and higher education. Since its founding in 1979, the ABC has grown from a small think tank in a single apartment into a global firm spanning nine offices on three continents. The ABC serves the world's most progressive hospitals and health care organization. Its U.S. members include:

- More than 94% of U.S. News & World Report's 2013 "Best Hospitals"
- More than 94% of U.S. News & World Report's 2013 "Best Children's Hospitals"
- More than 95% of the Leapfrog Group's 2012 "Top Hospitals"
- Eighty-eight of Thomson Reuters' "100 Top Hospitals"
- Ninety-three of the Healthgrades "100 Best Hospitals"

NHERT CEOs and their hospice programs are now officially members of ABC's Post-Acute Care Collaborative. NHERT is a collection of eleven non-profit and non-competing CEOs from across the country who meet in-person three times per year to develop and share industry best practices.

NATIONAL LEGISLATIVE UPDATE

2014 at a Glance

It's an election year, so most relevant activity is sure to be front-end loaded. Congressional leadership is unlikely to force hard votes on controversial issues past early spring and is likely to

focus on message issues (immigration, minimum wage, etc.) beyond that point, so here's what we are expecting the timeline to look like for issues relevant to the hospice community:

- Mid to late February – Baucus confirmation and Sustained Growth Rate (SGR) repeal ("Dr. Fix").
- March Medicare Payment Advisory Commission (MedPAC) Report to Congress – Medicare Advantage (MA) Carve In for Hospice recommendation will formally go to the Hill.
- Mid-March – President's proposed budget anticipated
- April 2014 – FY2015 Wage Index Notice of Rulemaking anticipated – could include plan for hospice payment reform. Additionally, Congress has scheduled at least one week-long district work period each month throughout the year, in addition to the six week long August-early September recess. A lame duck session of Congress is expected after the November election.

Active Issue Briefs

The October meeting of MedPAC was cancelled due to the government shutdown. Shortly after the government reopened, NHPCO met with MedPAC staff to gather information on the Commission's intention to alter the MA carve-out for hospice and make the case for the status quo. In the subsequent MedPAC meetings in November and December, the staff presented the concept of discontinuing the carve-out primarily on the basis of an opportunity to defragment care. The commissioners embraced the rationale and indicated their support in moving the recommendation forward. Additionally, the Commission discussed eliminating the hospice market basket update in 2015 and the length of stay trends and profit margins associated with the care hospice patients in the nursing home setting. NHPCO responded in early November with public comments to the Commission. At the January meeting, the Commission formalized two recommendations impacting the hospice community. As a reminder, the recommendations are made to Congress and will require Congressional support and action in order to implement.

1.) The Congress should include the Medicare hospice benefit in the Medicare Advantage benefits package beginning in 2016.

2.) The Congress should eliminate the update to hospice payment rates for fiscal year 2015.

Reimbursement Threats

All Medicare providers remain vulnerable to be included as offsets to pay for the SGR extension patches and/or a permanent repeal. Here's an overview of the possible scenarios:

1.) Full repeal of the SGR. This package would potentially cost $150 - $200 billion and have to be offset from a variety of sources. The majority of the money would have to come from an (unlikely) bipartisan compromise involving the Overseas Contingency Operations (OCO) funding and entitlement reform. A smaller portion of money would come from Medicare providers and all providers would be "on the table" in proportion to their Medicare spend. There is intense momentum around the effort to permanently repeal the SGR formula for Medicare physician reimbursement and end over a decade of short term patches that have largely been funded by cuts to other Medicare providers. However, the progress remains overshadowed by the difficulty in finding the offsets to pay for it, and move it along before Senate Finance Committee Chairman Max Baucus (D-MT) is confirmed as the U.S. Ambassador to China and leaves his post in the Senate.

2.) SGR patches continue. Should Congress fail to reach a compromise to permanently repeal the SGR formula for Medicare physician reimbursement, the patch cycle will continue. The current patch expires on March 31. Congress would likely extend the protection to the doctors through the end of the year and have to deal with it again in a post-election lame duck session. For short term patches, Medicare providers are the only offset considered by Congress. While the hospice community is not a target for cuts from a policy perspective, we are probably most vulnerable for cuts if the patch cycle continues. Hospice and Part D Relevant offices on the Hill and within the Administration are closely monitoring what comes out in the final guidance from CMS.

CONFLICT OF INTEREST POLICY STATEMENT

You will be asked to sign a conflict of interest policy statement for 2014. This is the same statement we used last year and it is required to be executed each year to meet the requirements of our annual audit and answer specific questions on the IRS Form 990, the nonprofit "tax" return. The document is included as an attachment to this report for you to review prior to Wednesday's meeting. We will have hard copies available for you to sign at the board meeting.

OUT AND ABOUT

I attended the NHERT meeting January 12 – 15 in Miami, FL. Guest speakers included representatives from the Advisory Board Company as we finalized NHERT's membership for 2014 and received introductory training on resources available to us.

ATTACHMENTS TO THIS PRESIDENT'S REPORT IMMEIDATELY FOLLOWING THIS SECTION OF THE .PDF

Dave Haley's Census Reports

2014 CHC Board of Directors Roster

Final 2013 Goals Report

2014 Goals

Conflict of Interest Policy Statement

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

December 2013 Financial Information.

Conflict of Interest Policy Statement

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, April 16, 2014 at 7:30 AM** in Conference Room A, first floor at the Mishawaka Campus, 501 Comfort Place, Mishawaka, IN 46545. In the meantime, if you have any questions, concerns, suggestions or comments, please contact me directly at 574-243-3117 or email mmurray@centerforhospice.org .

# # #

Center for Hospice Care

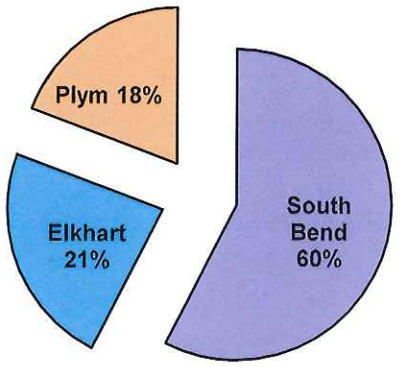
2014 YTD Average Daily Census (ADC)

(includes Hospice House and Home Health)

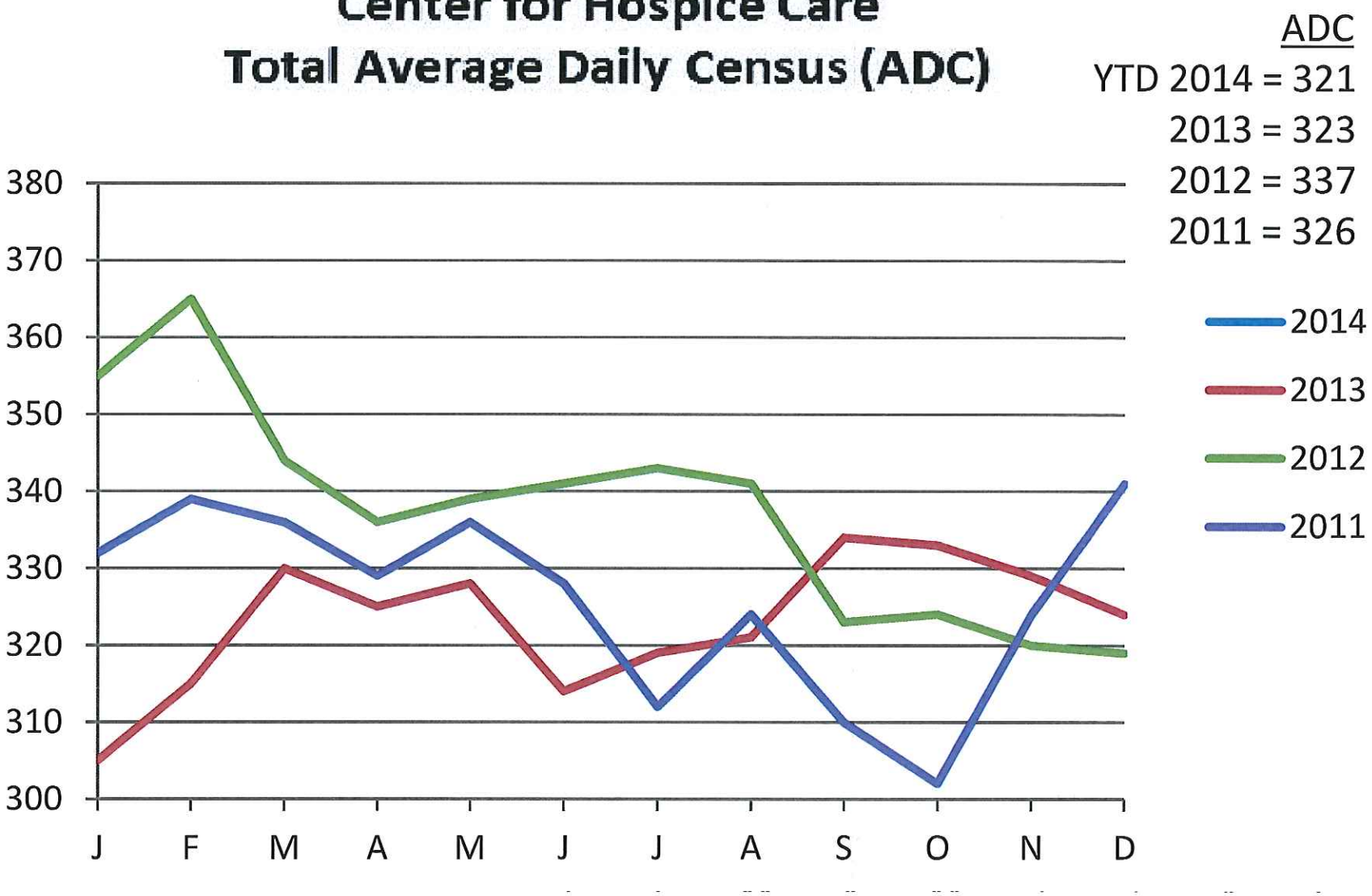
	All	South Bend	Elkhart	Plymouth
J	321	202	57	62
F				
M				
A				
M				
J				
J				
A				
S				
O				
N				
D				
2014 YTD Totals	321	202	57	62
2014 YTD ADC	**321**	**202**	**57**	**62**
2013 YTD ADC	305	187	60	58
YTD Change 2013 to 2014	16	15	-3	4
YTD % Change 2013 to 2014	**5.2%**	**8.0%**	**-5.0%**	**6.9%**

2014 YTD ADC by Branch

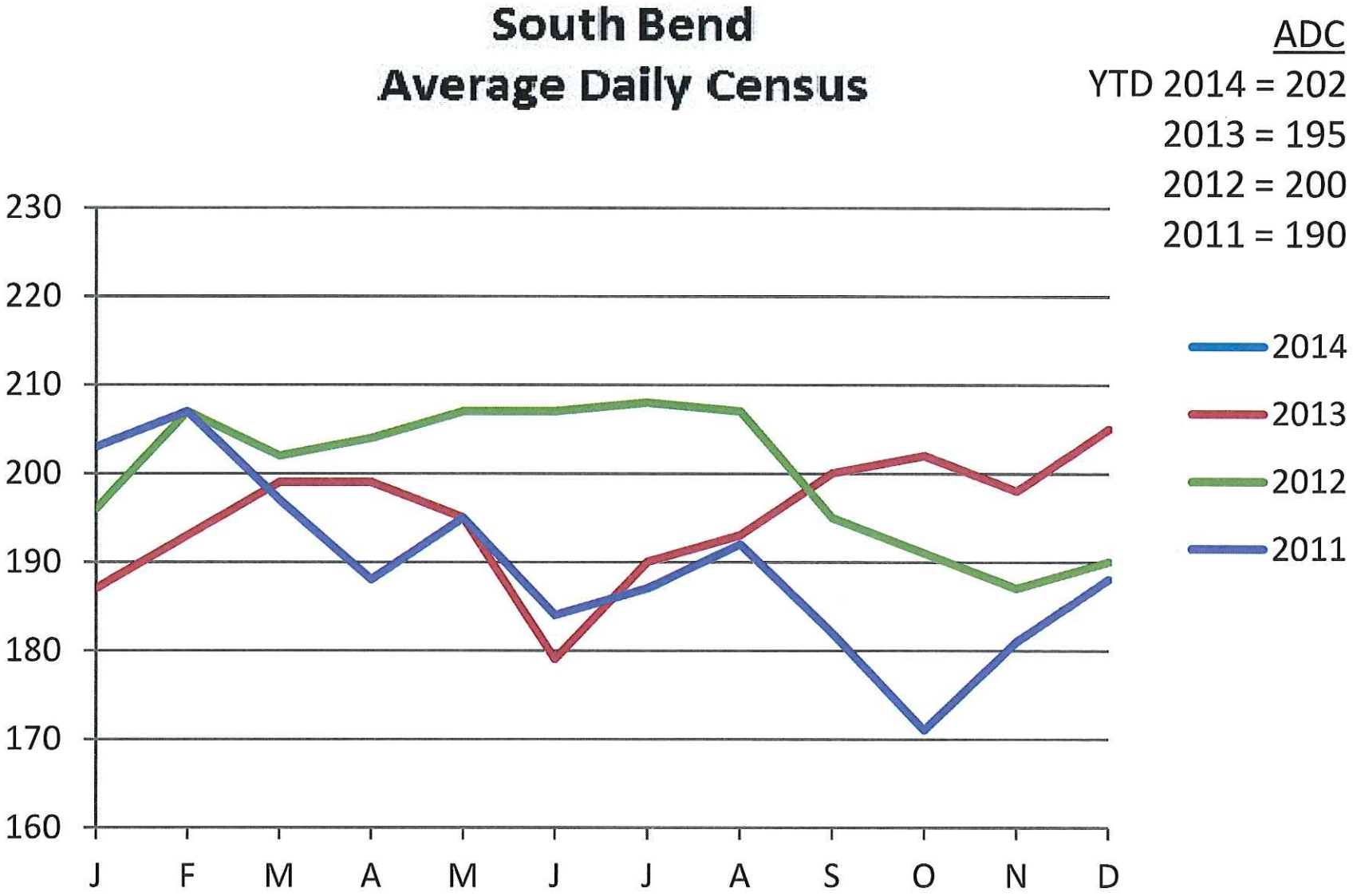
South Bend	62.9%
Elkhart	17.8%
Plymouth	19.3%
All	100%



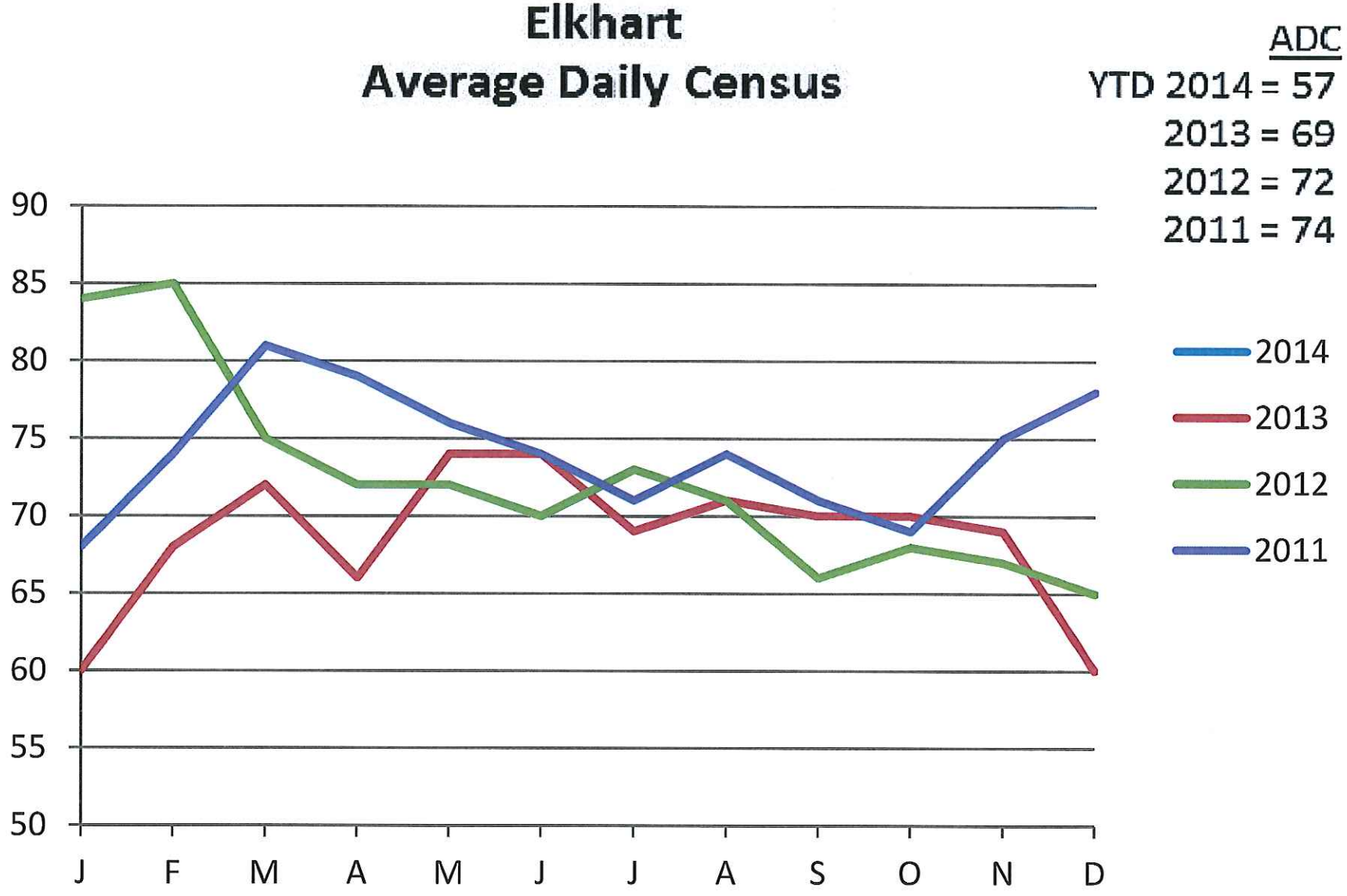
Center for Hospice Care
Total Average Daily Census (ADC)

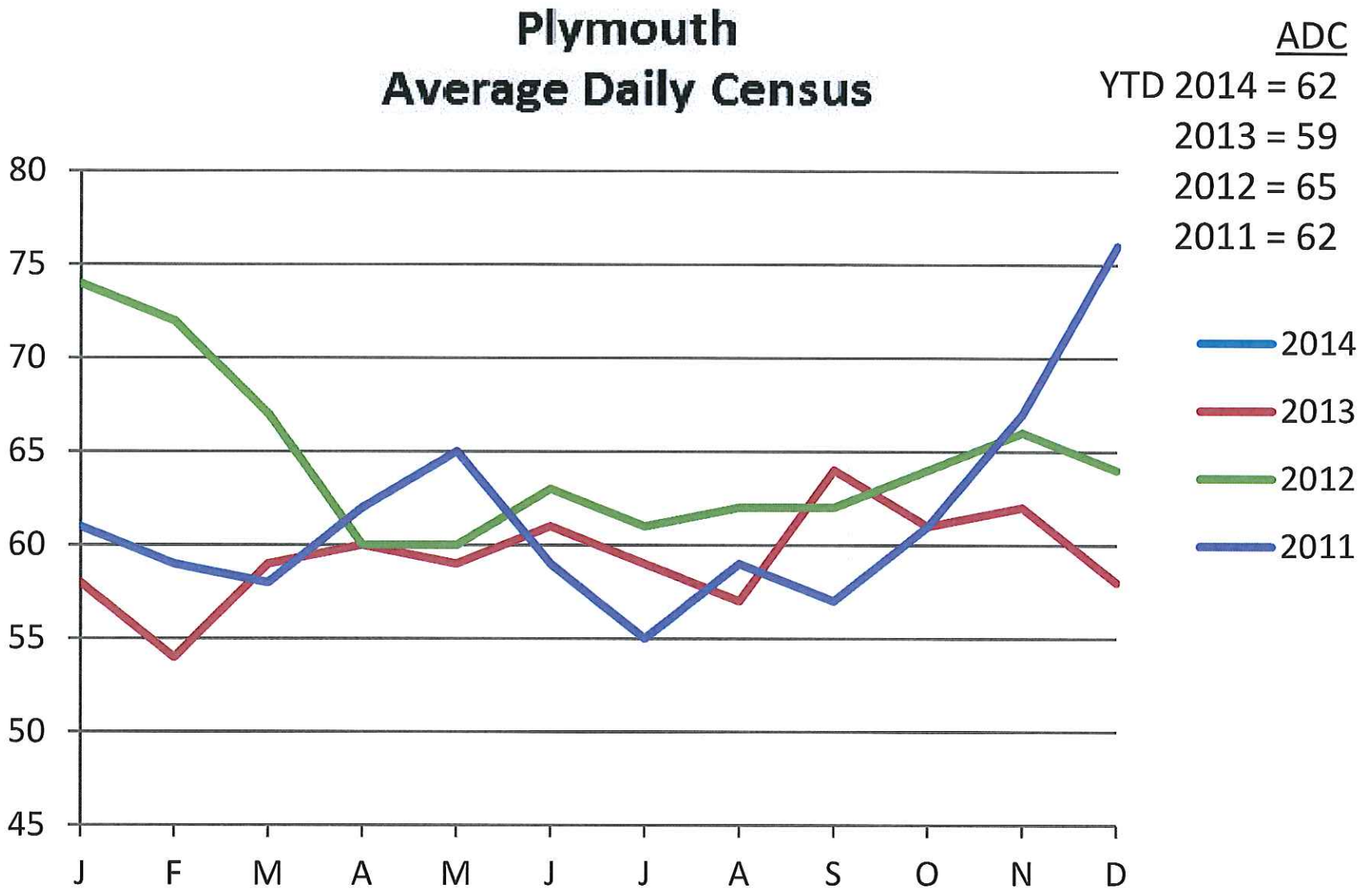


South Bend
Average Daily Census



Elkhart
Average Daily Census




Plymouth
Average Daily Census
ADC
YTD 2014 = 62
2013 = 59
2012 = 65
2011 = 62
2014
2013
2012
2011
80
75
70
65
60
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Center for Hospice Care

Goals for Calendar Year 2013

Updated 02/11/14

Goal A: Enhance Patient Care

Category	Status	Goal
Admissions	In Process	1. Increase referral conversion rate to 75%.
	In Process	2. Increase median length of stay by 30% (after completion of 3 year campaign).
	In Process	3. Increase average daily census by 25% (after completion of 3 year campaign).
	In Process	4. Increase same day referral/admissions by 33%.
	Met	5. Enhance marketing efforts for pediatric palliative care services.
Volunteers	In Process	1. Finalize and implement online training program.
	Met	2. Develop a teen program by recruiting and utilizing high school students age 16 and older as agency volunteers.
	Met	3. Increase personal contact with volunteers by face-to-face contact, mailing birthday cards, and making visits to homes and ECFs with patient care volunteers.
	Met	4. Roll out the Life Bio's program.
	Met	5. Review CAM program and determine validity of continuation and to what extent.
	Met	6. Increase number of patient care volunteers.
	Met	7. Increase social opportunities for volunteers by office and as an agency to increase team building relationships.
	In Process	8. Update volunteer section of the CHC website to include an electronic application packet, FAQ, and volunteer opportunities.
Nursing	In Process	1. Core Services 418.64 – Develop best practices in building caregiver confidence in delivery of care at patient end of life as measured in the FEHC. The goal is to be a leader of hospices in overall performance of caregiver confidence.
	Met	2. Interdisciplinary Group, Care Planning, and Coordination of Services 418.56 – Develop a comprehensive, uniform orientation and preceptor program to ensure high quality patient care, and encourage staff retention within the nursing department.
	Met	3. Quality Assessment and Performance Improvement 418.58 – Establish monthly, random chart audits by PCCs for their direct reports to ensure quality documentation reflects the assessment and care of the patient.
	Met	4. Quality Assessment and Performance Improvement 418.58 – Establish audit process to track bowel regime for those patients on opioid therapy.
	Met	5. Complete revision of Nursing Guidelines into a resource that reflects current clinical and Cerner processes.

Category	Status	Goal
	Met	6. Quality Assessment Process Improvement 418.58 – Continue QAPI projects for ongoing clinical outcome measures, and establish improvement goals.
	Met	7. Core Services 418.64 – Strengthen pediatric hospice services by establishing a Pediatric End of Life training program.
Bereavement, Social Work	Met	1. Introduce and monitor a new Team composition for the social work team.
	Met	2. Monitor the use of the new Social Service Progress Note that is being used by social workers.
	In Process	3. Develop and implement new problems, goals and objectives for the social work plan of care.
	Met	4. Monitor and ensure that "paperless" charts are meeting the needs of the bereavement team and the agency.
	Not Doing	5. Increase community awareness of bereavement services by increasing the number of community clients.
	Met	6. Explore providing online services/support groups for caregivers.
Spiritual Care	Not Doing	1. Research and enhance spiritual comfort measurement tool.
	Met	2. Finalize spiritual health assessment for primary caregivers and offer education to other disciplines.
	Met	3. Facilitate annual CHC memorial service.
	In Process	4. Establish guidelines to offer enough spiritual care contact to patients and families to improve FEHC scores from 4.7% to 3.9% (benchmark goal is 1.4%; National 2 year average is 3.9%).
Medical Directors	Met	1. Conclude the process of obtaining Elkhart medical staff consulting privileges for Drs. Gifford, Kubley.
	Met	2. Obtain membership for Drs. Gifford and Kubley on the Palliative Care subcommittee of St. Joseph, Memorial, and Elkhart General Hospitals.
	Met	3. Become affiliated with a Palliative Care Fellowship, with rotation of their Fellows through CHC.
	Met	4. Investigate advisory board opportunities for CHC participation, consultations, speaking opportunities, regularly scheduled rotated onsite palliative consultations by CHC medical directors.
	Not Doing	5. Assist Dr. Joe Banks in becoming board certified as a hospice and palliative care physician by 2014.

Goal B: Position for Future Growth

Category	Status	Goal
Foundation Staffing Additions	Met	1. Director of Major Gifts.
	In Process	2. Director of Education.
Technology	Met	1. Implement online presentations.
	Met	2. Create an electronic newsletter.

Category	Status	Goal
Mishawaka Campus	In Process	1. Secure a lead gift and cultivate prospective major donors.
	Met	2. Complete Phase I construction at Mishawaka campus.
	In Process	3. Complete Palliative Care Center remodel.
	Met	4. Complete Guest House remodel.
	Met	5. Work with City of Mishawaka to ensure smooth integration of public spaces with new hospice campus.
	Met	6. Aggressively pursue New Market Tax Credit opportunities for new Mishawaka campus.
	Met	7. Develop internal and external communication strategy.
Uganda	In Process	1. Secure grant funding for PCAU.
	Met	2. Work with PCAU/HAU to enhance palliative care training curriculum to include modules relating to social work, bereavement, spiritual care, and clinical officer-specific training.
	Met	3. Launch Crowd Funding initiative.
	Met	4. Film the "Road to Hope."
	Met	5. Fund up to ten CPCC scholarships.
	Met	6. Develop a CHC/PCAU Employee Exchange Program.
	Met	7. Co-sponsor and present at Bi-Annual PCAU Conference.
	Met	8. Develop a full range of internship opportunities with PCAU member organizations.
	Met	9. Work with Notre Dame to identify pre-med students for internships at Ugandan hospices.
	Met	10. Win the FHSSA Global Partnership Award.
Education	In Process	1. Develop Institute for Advance Care Planning website.
	In Process	2. Work with IU School of Medicine to become a site for their fellowship program in palliative medicine.
	In Process	3. Develop comprehensive end-of-life planning curriculum which can be delivered through local area professionals and faith communities.
	In Process	4. Work with IUSB to develop programs to offer CEU awarding seminars for local area professionals about end-of-life issues relevant to their profession.
	In Process	5. Launch new Institute for Hospice website.
	In Process	6. Develop initial online courses.
	In Process	7. Develop video education series about end-of-life planning matters using various local area professionals.
	In Process	8. Develop an *Okuyamba* teaching guide for delivery by FHSSA partners, colleges and universities.
	Met	9. Facilitate CHC staff teaching of Intro to Hospice and Palliative Care course at Notre Dame.

Category	Status	Goal
Administration	In Process Met In Process Met	1. Apply for the CMS Concurrent Care Demonstration Project. 2. Continue exploration and the intent to become a site for Residency Education in Palliative Medicine. 3. Expand upon chronic care case management experiences. 4. Investigate the development of a Private Duty line of business.

Goal C: Maintain Economic Strength

Fund Raising and Stewardship	Met In Process Met Met Met In Process Not Doing Met Met In Process In Process Met	1. Make an in-person visit to every funeral home in our service area. 2. Develop and implement planned giving program and materials. 3. Create a capital campaign strategy to raise money for new campus construction and specific programmatic needs. 4. Create new $25,000 donor giving level in Circle of Caring. 5. Create donor recognition wall at the Mishawaka campus to recognize cumulative giving. 6. Solicit corporate sponsors to underwrite printing and postage costs for Crossroads. 7. Develop corporate recognition award/fundraising events in Elkhart, Marshall and St. Joseph Counties to recognize companies/organizations that "improve the quality of living" in their region. 8. Conduct a donor satisfaction survey following the mailing of the 2012 Year in Review. 9. Develop standardized management reports for special events. 10. Ask a board member to host a cocktail party/open house as a way in which to raise awareness, potential donors, and prospective board members. 11. Launch five to seven year "Campaign for Hospice." 12. Begin discussions of new reasons to raise money if everyone has health insurance under the ACA.

Goal D: Continue Building Brand Identification

Category	Status	Goal
Marketing	Met In Process Met	1. Complete We Honor Veterans partnership requirements through Level 4. 2. Begin "score carding" by using explicit tools to create report cards between CHC and referral sources. Publish our pain and symptom scores. Promote CHC's QAPI data, FEHC scores, etc. 3. Continue market differentiation activities and promotion by creating Service Promises.

Center for Hospice Care

Goals for Calendar Year 2014

Updated 02/13/14

Goal A: Enhance Patient Care

Category	Status	Goal
Administration		1. Investigate and correct the low utilization of GIP at CHC Hospice Houses. 2. Contract with SNF medical directors to do Face-to-Face visits of CHC patients in their facilities. 3. Explore creating a separate physician practice corporation/entity to expand billing possibilities and positions for the future.
Admissions		1. Increase referral conversion rate to 70%. 2. Increase same day referral/admissions by 33%. 3. Decrease number of Missing Prognosis on Diagnosis Screen by 75%. 4. Scanning compliance 100%.
Volunteers		1. Finalize and implement online training program. 2. Update volunteer section of the CHC website to include an electronic application packet, FAQ, and volunteer opportunities. 3. Increase collaboration and support of ECFs in all service areas. 4. Get new volunteer training manual to all volunteers. 5. Continue to provide ongoing education and skills validation of patient care volunteers. 6. Improve collaborate with the Hospice Foundation staff in terms of volunteer participation and support for events. 7. Increase communication with the community liaisons. 8. Update volunteer training manual. 9. Recruit more male volunteers and patient care, pet visitation, and barber/hair stylist volunteers.

Category	Status	Goal
Nursing		1. Develop and implement Pediatric ELNEC training program for new nurse orientation. 2. Establish clinical staff training on QIS process and staff interviews for ECF survey audits. 3. Establish patient acuity rating and process to update changes in the medical record as the patient condition changes. 4. Complete Pediatric ELNEC staff training. 5. Establish nursing preceptor program. 6. Implement discharge hospice item set. 7. Implement OASIS C1. 8. Implement structured, internal study aids to assist staff nurses in preparation for the CHPN exam. 9. Perform QAPI studies over next year to improve quarterly FEHC scores on "top three opportunities for improvement." (D8 – Confidence in expectations while patient was dying; G2B – Family agreed with changes in the plan of care; D9 – Confidence in knowing what to do at time of death.)
Bereavement		1. Create and implement a systematic process for the Bereavement Department to contact and offer services to DBA bereaved. 2. Develop and implement an educational training program for the Mayo Clinic Fellows in Hospice and Palliative Medicine who will be rotating through CHC. 3. Explore possible resources for obtaining appropriate referrals from veteran organizations as an extension of the "We Honor Veterans" program. 4. Utilize a researched and validated tool to measure art counseling client improvement. 5. Perform QAPI study over next year and initiate procedures to further improve quarterly FEHC scores on question E4 (Emotional support to family AFTER patient's death).
Social Work		1. Develop and implement new problems, goals and objectives for the social work plan of care. 2. Assist in the development of the CHC Pediatric Palliative Care Program. 3. Ensure social workers are documenting in a timely manner and in the appropriate places in the chart. 4. Develop social work educational materials regarding initial assessment taking points, caregiving, VA benefits, algorithm for calling the police, reporting to APS. 5. Perform QAPI study over next year and initiate procedures to further improve quarterly FEHC scores on question B10 (Help with patient's feelings of anxiety or sadness).

Category	Status	Goal
Spiritual Care		1. Establish guidelines to offer enough spiritual care contact to patients and families to improve FEHC scores. 2. Define process for reviewing care plans – best practices. 3. Professional Chaplaincy Education – monthly from SCC who is assigned Reflection. 4. Address scale changes for Spiritual Comfort Measurement. 5. Host Pastoral Care Breakfast, October, 2014. 6. Coordinate with Bereavement and Admissions the offering of Spiritual Care services to families of patients who die before they are admitted (DBA's). They have chosen us, but just did not live long enough to become a patient. 7. Co-host annual Memorial Service, December 2014. 8. Perform QAPI study over next year and initiate procedures to improve quarterly FEHC scores on question E2 (Right amount of religious or spiritual contact).
Medical Directors		1. Establish CHC Medical Staff members as medical director/co-director/committee member of the Palliative Medicine Services of Memorial Hospital of South Bend and Kindred Hospital Northern Indiana, and then use these positions as opportunities to re-educate staff physicians regarding earlier H&PM referrals. (These positions have already been achieved at EGH and SJRMC.) 2. Assist in development of the CHC Pediatric Palliative Care Program. 3. Assist in recruitment of a fourth Board-Certified Hospice and Palliative Medicine Physician. 4. Staff the CHC Palliative Care Center upon its completion on the Mishawaka Campus. 5. Successfully function in our new capacities as Staff Physicians of both the Mayo Clinic and the Indiana University School of Medicine South Bend, teaching the Mayo Palliative Care Fellows, IU-SOM-SB medical students, and the SJRMC and Memorial Family Medicine residents. 6. Recruit new Face-to-Face Visit physicians from the local medical and ECF Medical Director community.

Goal B: Position for Future Growth

Category	Status	Goal
Administration		1. Apply for the CMS Concurrent Care Demonstration Project. 2. Explore creating a Geriatric Physician Practice component of part-time physicians (possibly retired) and specifically target ALFs.
Foundation Staffing		1. Hire Director of Education.
Mishawaka Campus		1. Secure a lead gift and cultivate prospective major donors. 2. Complete Palliative Care Center remodel. 3. Update internal and external communication strategy. 4. Complete Campus Grounds Project. 5. Design Phase II new construction. 6. Secure New Market Tax Credits for Phase I.
Uganda		1. Secure grant funding for PCAU. 2. Complete Road to Hope Film. 3. Host a *Circle of Caring* event in conjunction with Rose's visit. 4. Recruit and fund eight additional CPCC students from underserved districts in Uganda. 5. Establish internship program with Holy Cross College.
Education		1. Develop Institute for Advance Care Planning website. 2. Work with IU School of Medicine to become a site for their fellowship program in palliative medicine. 3. Develop comprehensive end-of-life planning curriculum which can be delivered through local area professionals and faith communities. 4. Work with local college(s) to develop programs to offer CEU awarding seminars for local area professionals about end-of-life issues relevant to their profession. 5. Develop initial online courses. 6. Develop video education series about end-of-life planning matters using various local area professionals. 7. Develop an *Okuyamba* teaching guide for delivery by FHSSA partners, colleges and universities.

Goal C: Maintain Economic Strength

Category	Status	Goal
Administration		1. Begin the development of new CHC resources to measure and manage pain and other symptoms in hospice patients using teachable innovative systems. 2. Begin a private duty line of business and test it first on the home health side of CHC's business.
Fund Raising and Stewardship		3. Develop and implement planned giving program and materials. 4. Solicit corporate sponsors to underwrite printing and postage costs for Crossroads. 5. Ask board members to invite friends to a campus event as a way in which to raise awareness, potential donors, and prospective board members. 6. Launch silent phase of 5-year "Cornerstones for Living: The Crossroads Campaign." 7. Create a Helping Hands Award Wall of Fame. 8. In collaboration with "We Believe" committee, host a thank you/stewardship event for all current "We Believe" fund donors. 9. Establish Mishawaka Campus outdoor memorial giving/commemoration opportunities similar to those at Elkhart Campus' Gardens of Remembrance.

Goal D: Continue Building Brand Identification

Category	Status	Goal
Administration		1. Explore finding partners with extended care facilities using the FHPC Pittsburg model as a basis for creating a partnership and formal affiliation agreement. 2. Begin exploring a program where the general public can make an appointment and come to the office and receive education and materials regarding advanced directives from a trained CHC professional. 3. Involve CHC staff in the creation of innovative, remarkable, memorable experiences to delight the senses for: the First Day of Patient Care, the First Day of Patient Care with children present, the First Day of Employment with CHC, the First Day of Volunteering, the First Contact from a new Referral Source, etc. 4. Begin the steps necessary to apply for the Circle of Life Award in 2015. 5. Begin efforts to gain an understanding of basic and advanced CHC customer segmentation and then create mechanisms to meet the diverse needs of CHC constituents.

Category	Status	Goal
Marketing		1. Begin “score carding” by using explicit tools to create report cards between CHC and referral sources. Publish our pain and symptom scores. Promote CHC’s QAPI data, FEHC scores, etc. 2. Update print collateral material (core and condensed brochures, dementia, Breathe Easy, grief services, volunteer, CAM). 3. Create a HeartWize brochure for referral sources. 4. Begin a digital marketing campaign focusing on St. Joseph County; track progress in three-month increments. 5. Enhance social media presence on Facebook and Twitter. 6. Post President’s blog twice a month (24 blogs written and ready to post). 7. Post Medical Director’s blog twice a month (24 blogs written and ready to post). 8. Update web photos and graphics.

Center for Hospice Care

Conflict of Interest Policy

Article 1

Purpose

The purpose of the conflict of interest policy is to protect the Center for Hospice Care's (CHC) interest when it is contemplating entering into a transaction or arrangement that might benefit the private interest of an officer or director of CHC or might result in a possible excess benefit transaction. This policy is intended to supplement but not replace any applicable state or federal laws governing conflict of interest applicable to nonprofit and charitable organizations.

Article II

Definitions

1. Interested Person – Any director, principal, officer, or member of a committee with governing board delegated powers, who has a direct or indirect financial interest, as defined below, is an interested person.

2. Financial Interest – A person has a financial interest if the person has, directly or indirectly, through business, investment, or family:
   a. An ownership or investment interest in any entity with which CHC has a transaction or arrangement,
   b. A compensation arrangement with CHC or with any entity or individual with which CHC has a transaction or arrangement, or
   c. A potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which CHC is negotiating a transaction or arrangement.

Compensation includes direct and indirect remuneration as well as gifts or favors that are not insubstantial.

A financial interest in not necessarily a conflict of interest. Under Article III, Section 2, a person who has a financial interest may have a conflict of interest only if the appropriate governing board or committee decides that a conflict of interest exists.

Article III

Procedures

1. Duty to Disclose – In connection with any actual or possible conflict of interest, an interested person must disclose the existence of the financial interest and be given the opportunity to disclose all material facts to the directors and members of committees with governing board delegated powers considering the proposed transaction and arrangement.

2. Determining Whether a Conflict of Interest Exists – After disclosure of the financial interest and all material facts, and after any discussion with the interested person, he/she shall leave the governing board or committee meeting while the determination of a conflict of interest is discussed and voted upon. The remaining board or committee members shall decide if a conflict of interest exists.

3. Procedures for Addressing the Conflict of Interest –
    a. An interested person may make a presentation at the governing board or committee meeting, but after the presentation, he/she shall leave the meeting during the discussion of, and the vote on, the transaction or arrangement involving the possible conflict of interest.
    b. The chairperson of the governing board or committee shall, if appropriate, appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.
    c. After exercising due diligence, the governing board or committee shall determine whether CHC can obtain with reasonable efforts a more advantageous transaction or arrangement from a person or entity that would not give rise to a conflict of interest.
    d. If a more advantageous transaction or arrangement is not reasonably possible under circumstances not producing a conflict of interest, the governing board or committee shall determine by a majority vote of the disinterested directors whether the transaction or arrangement is in CHC's best interest, for its own benefit, and whether it is fair and reasonable. In conformity with the above determination it shall make its decision as to whether to enter into the transaction or arrangement.

4. Violations of the Conflicts of Interest Policy
    a. If the governing board or committee has reasonable cause to believe a member has failed to disclose actual or possible conflicts of interest, it shall inform the member of the basis for such belief and afford the member an opportunity to explain the alleged failure to disclose.
    b. If, after hearing the member's response and after making further investigation as warranted by the circumstances, the governing board or committee determines the member has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

Article IV
Records of Proceedings

1. Records of Proceedings – The minutes of the governing board and all committees with board delegated powers shall contain:
    a. The names of the persons who disclosed or otherwise were found to have a financial interest in connection with an actual or possible conflict of interest, the nature of the financial interest, any action taken to determine whether a conflict of interest was present, and the governing board's or committee's decision as to whether a conflict of interest in fact existed.
    b. The names of the persons who were present for discussions and votes relating to the transaction or arrangements, the content of the discussion, including any alternatives to proposed transaction or arrangement, and a record of any votes taken in connection with the proceedings.

Article V
Compensation
1. A voting member of the governing board who receives compensation, directly or indirectly, from CHC for services is precluded from voting on matters pertaining to the member's compensation.

2. A voting member of any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from CHC for services is precluded from voting on matters pertaining to that member's compensation.
3. No voting member of the governing board or any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from CHC, either individually or collectively, is prohibited from providing information to any committee regarding compensation.

Article VI

Annual Statements

1. Annual Statements – Each director, principal officer and member of a committee with governing board delegated powers shall annually sign a statement which affirms such person:
   a. Has received a copy of the conflicts of interest policy,
   b. Has read and understands the policy,
   c. Has agreed to comply with the policy, and
   d. Understands CHC is charitable and in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of its tax-exempted purposes.

Article VII

Periodic Reviews

1. Periodic Reviews – To ensure CHC operates in a manner consistent with charitable purposes and does not engage in activities that could jeopardize its tax-exempt status, periodic reviews shall be conducted. The periodic reviews shall, at a minimum, include the following subjects:
   a. Whether compensation arrangements and benefits are reasonable, based on competent survey information and the result of arm's length bargaining.
   b. Whether partnerships, joint ventures, and arrangements with management organizations conform to CHC's written policies, are properly recorded, reflect reasonable investment or payments for goods and services, further charitable purposes and do not result in inurement, impermissible private benefit or in an excess benefit transaction.

Article VIII

Use of Outside Experts

1. Use of Outside Experts – When conducting the periodic reviews as provided for in Article VII, CHC may, but need not, use outside advisors. If outside experts are used, their use shall not relieve the governing board of its responsibility for ensuring periodic reviews are conducted.

_____ _____

Signature **Date**

2010