



June 25, 2010

**TO:** Mary Wakefield, Ph.D., R.N.  
Administrator  
Health Resources and Services Administration

**FROM:** /Lori S. Pilcher/  
Assistant Inspector General for Grants, Internal Activities,  
and Information Technology Audits

**SUBJECT:** Results of Limited Scope Review of Charles Drew Health Center, Inc.  
(A-07-10-02753)

The attached final report provides the results of our limited scope review of Charles Drew Community Health Center, Inc. This review is part of an ongoing series of reviews performed by the Office of Inspector General (OIG) to provide oversight of funds provided by the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act).

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the OIG post its publicly available reports on the OIG Web site. Accordingly, the final report will be posted at <http://oig.hhs.gov>.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to contact me at (202) 619-1175 or through email at [Lori.Pilcher@oig.hhs.gov](mailto:Lori.Pilcher@oig.hhs.gov). Please refer to report number A-07-09-02753 in all correspondence.

Attachment

Department of Health & Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**RESULTS OF  
LIMITED SCOPE REVIEW OF  
CHARLES DREW  
HEALTH CENTER, INC.**



Daniel R. Levinson  
Inspector General

June 2010  
A-07-10-02753

# ***Office of Inspector General***

<http://oig.hhs.gov>

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The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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## **EXECUTIVE SUMMARY**

### **BACKGROUND**

The Health Centers Consolidation Act of 1996 (P.L. No. 104–299) consolidated the Health Center Program under Section 330 of the Public Health Service Act (PHS Act), codified at 42 U.S.C. § 254(b). Pursuant to 42 U.S.C. § 254(b), the Health Center Program is a national program designed to provide comprehensive primary health care services to medically underserved populations through planning and operating grants to health centers. Within the U.S. Department of Health & Human Services, the Health Resources and Services Administration (HRSA) administers the Health Center Program. The HRSA health centers are community-based and patient-directed organizations that serve populations with limited access to health care.

Under the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, HRSA received \$2.5 billion, including \$2 billion to expand the Health Center Program to serve more patients, stimulate new jobs, and meet the significant increase in demand for primary health care services among the Nation’s uninsured and underserved populations. These appropriations included \$500 million for grants to health centers, \$1.5 billion for health center construction, renovation, and equipment and for the acquisition of health information technology systems, and \$500 million to address health professions workforce shortages. HRSA made available four types of Recovery Act grants to health centers: new access points, increased demand for services (IDS), facilities investment program, and capital improvement program (CIP). Recovery Act grants were provided to both new and existing health centers; moreover, a center was permitted to receive more than one type of grant.

Charles Drew Health Center, Inc. (CDHC), has provided health care to families at four different locations in metropolitan Omaha, Nebraska, since 1983. On March 17, 2009, CDHC applied for Recovery Act IDS grant funding in the amount of \$334,290 to retain five key staff positions. According to CDHC’s application for IDS funds, the grant would enable CDHC to serve 432 new uninsured and 232 underinsured patients in metropolitan Omaha, Nebraska. On March 27, 2009, HRSA awarded CDHC an IDS grant in the amount of \$334,290.

On June 2, 2009, CDHC applied for Recovery Act CIP grant funding in the amount of \$681,400 to purchase a practice management and electronic health records system. According to CDHC’s application for CIP funds, the grant would enable CDHC to improve efficiency, ensure Health Insurance Portability and Accountability Act compliance, and improve patient safety and quality of care. On June 25, 2009, HRSA awarded CDHC a CIP grant in the amount of \$681,400.

### **OBJECTIVE**

Our objective was to assess CDHC’s financial viability, capacity to manage and account for Federal funds, and capability to operate a community health center in accordance with Federal regulations.

## **RESULTS OF REVIEW**

Based on our assessment, we believe CDHC is financially viable, has the capacity to manage and account for Federal funds, and is capable of operating its health center in accordance with Federal regulations. However, we identified several weaknesses in CDHC's financial management: deteriorating cash position, untimely bank account reconciliations, absence of written policies and procedures for adherence to Federal Deposit Insurance Corporation limits, inadequate segregation of duties, non-performance of fixed asset inventory counts, and an improper documentation of sliding fee discounts.

## **RECOMMENDATION**

When monitoring the Recovery Act funds, we recommend that HRSA consider the information presented in this report in assessing CDHC's ability to account for and manage Federal funds and to operate a community health center in accordance with Federal regulations.

## **AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, CDHC neither agreed nor disagreed with our findings, but it described corrective action that it had implemented to address each of our findings. CDHC's comments are included in their entirety as the Appendix.

After reviewing CDHC's comments, we maintain that our findings are valid.

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## INTRODUCTION

### BACKGROUND

#### **The Health Center Program**

The Health Centers Consolidation Act of 1996 (P.L. No. 104–299) consolidated the Health Center Program under Section 330 of the Public Health Service Act (PHS Act), codified at 42 U.S.C. § 254(b). Pursuant to 42 U.S.C. § 254(b), the Health Center Program is a national program designed to provide comprehensive primary health care services to medically underserved populations through planning and operating grants to health centers. Within the U.S. Department of Health & Human Services (HHS), the Health Resources and Services Administration (HRSA) administers the Health Center Program.

The Health Center Program provides grants to nonprofit private or public entities that serve designated medically underserved populations and areas, and vulnerable populations composed of migrant and seasonal farm workers, the homeless, and residents of public housing. Health centers funded by HRSA are community-based and patient-directed organizations meeting the definition of “health center” under 42 U.S.C. § 254(b).

Under the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, HRSA received \$2.5 billion, including \$2 billion to expand the Health Center Program to serve more patients, stimulate new jobs, and meet the significant increase in demand for primary health care services among the Nation’s uninsured and underserved populations. These appropriations included \$500 million for grants to health centers, \$1.5 billion for health center construction, renovation, and equipment and for the acquisition of health information technology systems, and \$500 million to address health professions workforce shortages. HRSA made available four types of Recovery Act grants to health centers: new access points, increased demand for services (IDS), facilities investment program, and capital improvement program (CIP). Recovery Act grants were provided to both new and existing health centers; moreover, a center was permitted to receive more than one type of grant.

#### **Charles Drew Health Center, Inc.**

Charles Drew Health Center, Inc. (CDHC), has provided health care to families in metropolitan Omaha, Nebraska, since 1983. Health care services provided include family practice, internal medicine, pediatrics, obstetrics/gynecology, pharmacy, radiology, eye services, minor surgery, cardiology and podiatry. CDHC provides health services at four Omaha locations, including two primary care clinics and two homeless program centers. In 2008, CDHC served 12,328 patients and facilitated 43,029 patient visits.

Additionally, over a dozen special programs are conducted at CDHC’s facilities and through outreach programs and satellite centers. These programs include education, prevention, and health care in the areas of infant mortality; sexually transmitted diseases; the supplemental nutrition program for Women, Infants and Children; homeless health care; human

immunodeficiency virus testing and counseling; optical services; pharmacy services; behavioral health; and social services.

The CDHC Foundation was established to serve as a related-party fundraiser for CDHC. The CDHC Foundation is governed by its own Board of Directors which oversees the foundation's fundraising activities, but which does not participate in the governance or operation of CDHC. The CDHC Foundation and CDHC file separate tax returns with the Internal Revenue Service, but the two entities are combined for financial statement purposes.

On March 17, 2009, CDHC applied for Recovery Act IDS grant funding in the amount of \$334,290 to retain five key staff positions. According to CDHC's application for IDS funds, the grant would enable CDHC to serve 432 new uninsured and 232 underinsured patients in metropolitan Omaha, Nebraska. On March 27, 2009, HRSA awarded CDHC an IDS grant in the amount of \$334,290.

On June 2, 2009, CDHC applied for Recovery Act CIP grant funding in the amount of \$681,400 to purchase a practice management and electronic health records system. According to CDHC's application for CIP funds, the grant would enable CDHC to improve efficiency, ensure Health Insurance Portability and Accountability Act compliance, and improve patient safety and quality of care. On June 25, 2009, HRSA awarded CDHC a CIP grant in the amount of \$681,400.

### **Requirements for Federal Grantees**

Nonprofit organizations that receive HRSA funds must comply with Federal cost principles found at 2 CFR pt. 230, *Cost Principles for Non-Profit Organizations* (formerly Office of Management and Budget (OMB) Circular A-122). In addition, 42 U.S.C. § 254(b) defines requirements for health centers under the Health Center Program.

The Standards for Financial Management Systems found at 45 CFR § 74.21, establish regulations for grantees to maintain financial management systems. Grantees' financial management systems must provide for accurate, current, and complete disclosure of the financial results of each HHS-sponsored project or program (45 CFR § 74.21(b)(1)); must ensure that accounting records are supported by source documentation (§ 74.21(b)(7)); and must provide effective control over and accountability of all funds, property, and other assets so that recipients adequately safeguard all such assets and assure they are used solely for authorized purposes (§ 74.21(b)(3)). Grantees also must have written procedures for determining the reasonableness, allocability, and allowability of costs in accordance with the provisions of the applicable Federal cost principles and the terms and conditions of the award (§ 74.21(b)(6)).

In addition, grantees must establish written procurement procedures that include certain provisions as set forth in 45 CFR § 74.44. Federal regulations also require grantees to deposit and maintain advances of Federal funds in insured accounts whenever possible (45 CFR § 74.22(i)(2)).

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to assess CDHC's financial viability, capacity to manage and account for Federal funds, and capability to operate a community health center in accordance with Federal regulations.

### **Scope**

We conducted a limited review of CDHC's financial viability, financial management system, and related policies and procedures. Therefore, we did not perform an overall assessment of CDHC's internal control structure. Rather, we performed limited tests and other auditing procedures on CDHC's financial management system to assess its ability to administer federally funded projects.

We performed our fieldwork at CDHC's administrative office in Omaha, Nebraska, during January 2010.

### **Methodology**

To accomplish our objective, we:

- reviewed relevant Federal laws, regulations, and guidance, to include HRSA program and policy announcements;
- obtained and reviewed CDHC's HRSA grant application packages and supporting documentation;
- interviewed CDHC personnel to gain an understanding of its accounting systems and internal controls;
- reviewed CDHC's audited financial statements and supporting documentation for the period September 1, 2007, through August 31, 2008;
- reviewed CDHC's unaudited financial statements, IRS Forms 990, and supporting documentation for the period September 1, 2007, through August 31, 2009;
- performed ratio analyses of CDHC's financial statements;
- evaluated CDHC's fiscal procedures related to accounting documentation and preparation of financial reports;
- evaluated CDHC's current program operations;

- reviewed CDHC's administrative procedures related to personnel, record-keeping, conflict resolution, and other non-financial matters;
- reviewed minutes from CDHC's Board of Directors meetings; and
- provided a summary of our findings to CDHC's management on February 11, 2010.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

## **FINDINGS AND RECOMMENDATION**

Based on our assessment, we believe CDHC is financially viable, has the capacity to manage and account for Federal funds, and is capable of operating its health center in accordance with Federal regulations. However, we identified several weaknesses in CDHC's financial management: deteriorating cash position, untimely bank account reconciliations, absence of written policies and procedures for adherence to Federal Deposit Insurance Corporation limits, inadequate segregation of duties, non-performance of fixed asset inventory counts, and an improper documentation of sliding fee discounts.

### **WEAKNESSES IN FINANCIAL MANAGEMENT**

#### **Deterioration in Cash Position**

Pursuant to 45 CFR § 74.21(b)(3)), grantees' financial management systems must provide effective control over and accountability of all funds, property, and other assets so that recipients adequately safeguard all such assets and assure they are used solely for authorized purposes. The combined CDHC and CDHC Foundation cash and equivalents balance decreased by approximately 62 percent between August 31, 2008, and November 30, 2009. In addition, during the same period, CDHC's number of days' operating expenses covered by cash balance decreased from 22 days to 11 days.

CDHC recently established two lines of credit: a \$600,000 line of credit, opened on December 2, 2009, of which \$300,000 was outstanding as of January 26, 2010; and a \$100,000 line of credit, opened on September 4, 2009, of which \$96,000 was outstanding as of December 30, 2009.

However, CDHC's current ratio was 1.26 as of November 30, 2009. Current ratio is a measure of liquidity which is calculated by dividing an entity's current assets by its current liabilities. A current ratio in excess of 1.00 suggests that a company would be able to pay off its obligations if they came due at that point. In addition, CDHC had fixed assets, net of depreciation, of \$5,304,025 and no outstanding long-term debt. CDHC's decreasing cash balance, which we noted at the time of our fieldwork, was partially attributable to the payoff of a mortgage loan

related to a building renovation and expansion completed in 2007. CDHC management indicated that CDHC's cash position should improve as new medical personnel hired during the expansion are able to establish a larger patient base. Thus, we concluded that CDHC's deterioration of cash position was a temporary condition that did not appear to put into doubt the entity's long-term status as a viable and going concern.

### **Untimely Bank Account Reconciliations**

Pursuant to 45 CFR § 74.21(b)(3), grantees' financial management systems must provide effective control over and accountability of all funds, property, and other assets so that recipients adequately safeguard all such assets and assure they are used solely for authorized purposes.

CDHC did not reconcile its operating account bank statement to the general ledger account balance in a timely manner. As of January 20, 2010, the CDHC operating account had been reconciled only through September 30, 2009. Untimely reconciliation of bank accounts could lead to delay or inability to detect accounting inaccuracies and/or misappropriation of assets by theft or fraud.

### **Absence of Written Policy for Adherence to Federal Deposit Insurance Corporation Deposit Insurance Limits**

Pursuant to 45 CFR § 74.21(b)(3), grantees' financial management systems must provide effective control over and accountability of all funds, property, and other assets so that recipients adequately safeguard all such assets and assure they are used solely for authorized purposes. In addition, pursuant to 45 CFR § 74.22(i)(2), grantees are required to deposit and maintain advances of Federal funds in insured accounts whenever possible. Federal Deposit Insurance Corporation (FDIC) policy states that deposits owned by a corporation, partnership, or unincorporated association are insured up to \$250,000 at a single bank.

CDHC's written cash management policy did not include policies and procedures to ensure that cash balances did not exceed federally insured limits. CDHC exceeded the \$250,000 FDIC account limit by as much as \$456,000 for a two-day period in September 2009. Funds that exceed FDIC limits are subject to an increased risk of loss in the event of a bank failure.

Prior to the completion of our audit fieldwork, CDHC revised its written cash management policy to include policies and procedures that would adequately address FDIC insurance limits.

### **Inadequate Segregation of Duties**

Pursuant to 45 CFR § 74.21(b)(3), grantees' financial management systems must provide effective control over and accountability of all funds, property, and other assets so that recipients can adequately safeguard all such assets and assure they are used solely for authorized purposes. In addition, pursuant to 42 USC § 254b(1)(3)(D) and 45 CFR §§ 74.14, 74.21, and 74.26, a health center must maintain separate functions appropriate to organizational size to safeguard assets and maintain financial stability.

CHDC staff did not adequately segregate financial management duties in the following high-risk areas:

- **Cash Receipts:** The Accountant performs custody, recording, and reconciliation duties related to cash receipts. These duties should be performed by separate individuals to ensure the integrity of the cash receipts function.
- **Cash Disbursements:** The Chief Financial Officer has access to perform both the authorization and the recording duties related to cash disbursements. These duties should be performed by separate individuals to ensure the integrity of the cash disbursements function.

Inadequate segregation of duties could result in delay or inability to detect accounting inaccuracies and/or misappropriation of assets by theft or fraud.

### **Fixed Asset Inventory Count Not Performed**

Pursuant to 45 CFR § 74.21(b)(3)), grantees' financial management systems must provide effective control over and accountability of all funds, property, and other assets so that recipients adequately safeguard all such assets and assure they are used solely for authorized purposes. In addition, 45 CFR §§ 74.34(f)(3) and 74.44(a) require grantees to establish written procurement procedures and to maintain inventory control systems and take periodic physical inventory of grant-related equipment.

CDHC did not perform any fixed asset inventory counts during 2008 and 2009. (As stated earlier, CDHC had fixed assets, net of depreciation, of \$5,304,025 as of November 30, 2009.) Nonperformance of fixed asset inventory counts could lead to a misstatement of fixed asset balances in financial statements and/or a delay or inability to detect misappropriation of assets by theft or fraud.

### **Improper Documentation of Sliding Fee Discounts**

Pursuant to 42 CFR § 51c.303(f), health centers must have a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. Discounts in the fees for medical services that are based upon the extent to which the patient is able to pay those fees are commonly referred to as sliding fee discounts.

CDHC had a system in place to determine eligibility for sliding fee discounts; however, prior testing performed by CDHC's independent auditor found that CDHC could not provide proper supporting documentation for all of the sliding fee discounts that CDHC had granted.

At the time of our site visit, CDHC was in the process of implementing revisions to its sliding fee discount policies and procedures in response to the independent auditor's finding. Because the timing of the implementation coincided with our site visit, we were unable to test the revised policies and procedures to determine whether the independent auditor's prior audit finding was satisfactorily resolved.

## **RECOMMENDATION**

When monitoring the Recovery Act funds, we recommend that HRSA consider the information presented in this report in assessing CDHC's ability to account for and manage Federal funds and to operate a community health center in accordance with Federal regulations.

## **AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, CDHC neither agreed nor disagreed with our findings, but it described corrective action that it had implemented to address each of our findings. CDHC's comments are included in their entirety as the Appendix.

After reviewing CDHC's comments, we maintain that our findings are valid.

# **APPENDIX**

## APPENDIX: AUDITEE COMMENTS

Charles Drew Health Center, Inc. – H80CS00438



**Charles Drew Health Center, Inc.**  
"Growing A Healthy Community"

2915 Grant Street  
P. O. Box 111609  
Omaha, Nebraska 68111  
Health Center 402.451.3553  
Administration 402.457.1200  
Fax 402.457.1220  
CharlesDrewHCOmaha.org

May 14, 2010

Mr. James Korn, Audit Manager  
Region VII  
601 East 12<sup>th</sup> Street, Room 0429  
Kansas City, Missouri 64106

Dear Mr. Korn:

RE: Response to the U.S. Department of Health & Human Service  
Office of Inspector General (OIG) Draft Report  
Draft Report: Result of Limited Scope Review of Charles Drew Health Center  
Dated May 2010; Report Number: A-07-10-02753

After an extensive review and discussion of the DRAFT report presenting by the Department of Health & Human Services, Office of Inspector General (OIG), Results of Limited Scope Review of Charles Drew Health Center, Inc., and a complete review of the final report, the CDHC senior level administrative team have taken the findings under consideration and prepared the following responses to each recommendation. Please note that documentation to support all responses is available upon request.

### **Finding - Deterioration in Cash Position**

- **Finding** – The combined CDHC and CDHC Foundation cash and equivalents balance decreased by approximately 62 percent between August 31, 2008, and November 30, 2009. In addition, during the same period, CDHC's number of day's operating expenses covered by cash balance decreased from 22 days to 11 days.
- **Response** – In compliance with the 2010-11 Notice of Grant Award, Charles Drew Health Center prepared a Recovery Plan based on projected cash flows for the purpose of improving its financial position and for complying with HRSA's financial guidelines. The plan was submitted May 5, 2010. HRSA has reviewed the plan and a telephone conference will be held Wednesday, May 12, 2010 at 12:00 noon (CST) to discuss the plan.

Charles Drew Health Center, Inc. – H80CS00438

**Finding - Untimely Bank Account Reconciliation**

- Finding - CDHC did not reconcile its operating account bank statement to the general ledger account balance in a timely manner.
- Response – The reconciliation for the operating account bank statement for September 30, 2009 has been completed and as of April 2010, the CDHC operating account has been reconciled to the general ledger.

Beginning May 1, 2010, the CEO will meet monthly with the CFO, the accountant and the accounting staff to insure that all bank reconciliations are completed for the previous month. Failure to meet expectations of timely reconciliation will be addressed and documented through established CDHC personnel policies and procedures and the annual performance evaluation process.

**Finding - Absence of Written Policy for adherence to Federal Deposit Insurance Corporation Deposit Insurance Limits**

- Finding – CDHC’s written cash management policy did not include policies and procedures to ensure that cash balances did not exceed federally insure limits.
- Response – Prior to the completion of the audit fieldwork, the CDHC written cash management policy was revised to include policies and procedures that ensured that cash balances did not exceed the specified federal insured limits of \$250,000. A copy of the policy is available upon request.

**Finding - Inadequate Segregation of Duties**

- Finding – CDHC staff did not adequately segregate financial management duties in the following high-risk areas: (1) Cash Receipts - the accountant performs custody, recording, and reconciliation duties related to cash receipts; and (2) Cash Disbursements – the chief financial officer has access to perform both the authorization and the recording duties related to cash disbursements.
- Response – Effective March 19, 2010, the accountant’s duties for custody and recording cash receipts was reassigned to the accounting clerks. In addition, all blank check stock is no longer secured by the CFO. Blank check stock is now secured by the CEO in a locked cabinet in the CEO’s office. Only building security has keyed access to the CEO’s office and only the CEO has access to the secured cabinet.

In addition, the CEO has accessed the general ledger security system and amended the system so that the CFO no longer has access/rights to the accounts payable system.

Charles Drew Health Center, Inc. – H80CS00438

CDHC has plans to hire another accountant during FY2011 to assist with specific accounting functions with the goal of further segregating financial management duties.

**Finding – Fixed Asset Inventory Count Not Performed**

- Finding – CDHC did not perform any fixed asset inventory counts during 2008 and 2009.
- Response – As of April 20, 2010, a fixed asset inventory was completed of all CDHC assets. A copy of the completed inventory is available upon request. According to law, CDHC will conduct a review every other year. The next fixed asset inventory will be completed on or before April 30, 2012.

**Finding - Sliding Fee Program**

- Finding – CDHC had a system in place to determine eligibility for sliding fee discounts; however, prior testing performed by CDHC's independent auditor found that CDHC could not provide proper supporting documentation for all of the sliding fee discounts that CDHC had granted.
- Response – The CDHC Sliding Fee policy has been amended. On May 5, 2010 CDHC submitted a copy of its revised policy to HRSA as a part of its 2010-11 Notice of Grant Award conditions. A copy of the current CDHC Sliding Fee policy is available upon request.

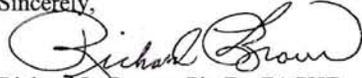
The amended policy states that the Business Officer Coordinator will review all sliding fee documentation on a daily basis prior to submitting it to file. Further, procedures have been implemented to emphasize to front desk staff, as a part of its mandatory meetings, the importance of retaining all documentation required for determining patient eligibility. In addition, as a check and balance procedure, the Director of Finance will conduct an audit each month to ensure proper documentation is on file.

Failure to meet expectations of timely review of sliding fee documentation and/or retention of documentation for determining patient eligibility will be addressed and documented through established CDHC personnel policies and procedures and the annual performance evaluation process.

Charles Drew Health Center, Inc. – H80CS00438

If you have questions or require additional information and documentation, please feel free to contact me at (402) 457-1200 ext. 236 or via email at [richardb@cdhcmedical.com](mailto:richardb@cdhcmedical.com). You may also contact Mr. Calvin McGruder, CDHC Chief Financial Officer. Mr. McGruder can be reached at (402) 457-1215 or via email at [calvinm@cdhcmedical.com](mailto:calvinm@cdhcmedical.com).

Sincerely,



Richard L. Brown, Ph. D., FACHE  
Chief Executive Officer

Cc: Calvin McGruder, CDHC Chief Financial Officer  
Julieta Clarke, CDHC Board President  
CDHC Board of Directors