AGENDA

Commission on Healthcare and Hospital Funding

Meeting Date | ***Time:*** 6/17/2015 8:00 AM – 12:00 PM
Dial-in Number: 1-888-670-3525 | **Dial-in Access Code:** 116 985 4595

Objective: ***To Determine Role of Taxpayer Supplemental Funding on Hospitals***

Time	Item/Activity	Presenter
8:00-8:15	• Call to Order • Roll Call • Approval of June 4 meeting minutes	Mr. Beruff
8:15-8:45	Presentation from Tampa General Hospital	Dr. James Burkhart
8:45-9:00	Q&A with Dr. Burkhart	Commission Members
9:00-9:05	Introduction	Mr. Beruff
9:05-10:15	Guest Speaker: Dr. Marty Makary	Dr. Makary
10:15-10:30	Q&A with Dr. Makary	Commission Members
10:30-10:40	Break	(All)
10:40-11:10	Presentation from Morton Plant Hospital	Mr. Kristopher Hoce
11:10-11:25	Q&A with Mr. Hoce	Commission Members
11:25-11:35	Commission Member Discussion	Commission Members
11:35-11:45	Public Comment Period*	Mr. Beruff
11:45-12:00	Meeting Summary, wrap up, and next steps	Mr. Beruff

**Persons participating by teleconference may submit public comments through electronic mail to:* FLHospitalCommission@ahca.myflorida.com

DRAFT MEETING MINUTES

COMMISSION ON HEALTHCARE AND HOSPITAL FUNDING

Meeting Date: June 4, 2015

Time: 8:00 a.m. – 12:00 p.m.

Location: The Florida State Capital, Cabinet Meeting Room

Members Present: Carlos Beruff, Chair (by phone); Tom Kuntz, Vice Chair; General Chip Diehl; Marili Cancio Johnson; Eugene Lamb; Dr. Jason Rosenberg; Sam Seevers (by phone); Dr. Ken Smith and Robert Spottswood.

Executive Directors Present: Dr. John Armstrong, State Surgeon General and Secretary of Health and Elizabeth Dudek, Secretary of the Agency for Healthcare Administration.

DOH and AHCA Administrators and Staff Present: Cruz Conrad, Nathan Dunn, Beth Eastman, Marisol Fitch, Ryan Fitch, Stacey Lampkin, Mandi Manzie, Molly McKinstry, Jennifer Miller, Karen Riviere, David Rodgers, Jamie Sowers and Josh Spagnola.

Interested Parties Present: Bill Bell, FHA; Steve Birtman, Florida Association of Nurse Anesthetists; Donna Clarke, Lee Memorial Health System; Marti Coley, Nemours Children Hospital; Vanesa Charles, Bob, Levy & Associates; Brian Delburn, Tenet Healthcare; Jan Gorrie, Ballard Partners; Wendy Hedrick, Sunshine Health; Lori Hundley; Sally Jackson, Lee Memorial Health System; Ashley Kalifeh, Capital City Consulting; Laura Lenhart, Moffitt Cancer Center; Danny Martell, Economic Council of Palm Beach County; James Miller, Capitol Access; Phillis Oeters, Baptist Health South Florida; Brittany O'neil, Department of Financial Services – Division of Workers' Compensation; Jose Romano, Baptist Health; Rob Shave, Access Capital, Corp.; Jess Scher, United Way of Miami-Dade; Ron Watson, Watson Strategies

Media: Matt Galka, Capitol News Service; Thomas Jones, Florida Channel; Christine Sexton

Welcome and Introductions: Carlos Beruff, Chair, called into the meeting from the phone and asked that Tom Kuntz, Vice Chair, facilitate the meeting. Vice Chair Kuntz called the meeting to order.

Review and Approval of May 26th Meeting Minutes: Vice Chair Kuntz called for a review and approval of the minutes from the May 26, 2015 commission meeting. Ms. Marili Cancio Johnson noted that on page four there was an error, she meant 30 percent not 30 billion. With the error noted and corrected, the minutes were approved.

Commission Member Comments and Discussion: Vice Chair Kuntz encouraged each Commission member to take inventory of the path that the Commission has taken and comment upon that path. All of the Commissioners thanked the staff for providing an enormous amount of information on very short notice as well as being available to Commission members when needed.

Dr. Jason Rosenberg noted that he would to explore how to incentivize hospital behaviors for the Commission's desired outcomes. Mr. Robert Spottswood articulated the difficulty of getting through the information provided and knowing what the Commission is tasked with accomplishing. He indicated that he would like more information on all governmental funding hospitals receive, a breakdown of funds including each governmental funding source and how the governmental sources are dispersed.

Dr. Smith stated that the current process is complicated and due to the amount of information, slow-going. He challenged the Commission to boil down the information it is receiving and the process to its so that it will be accessible information to the constituents of the state of Florida.

Surgeon General Armstrong thanked the Commissioners in addressing the tough questions in order to enrich the citizens of Florida. He indicated that the Commission needs to continue its task to find where taxpayer money is going and what are the expectations attached to that money. Secretary Dudek also thanked the Commissioners for providing the Agency with a new perspective on the data. She encouraged the Commission to continue to ask questions so as to provide recommendations that will further affordability and accessibility of healthcare to Floridians.

General Chip Diehl stated the importance of the Commission sticking to the facts and importance of staying ahead of the curve. He noted that there is a lot of money but the Commission needs to keep in mind the impact of that money on the state. General Diehl also indicated that the Commission needs to continue to keep the aperture open as wide as possible to consider all aspects, including provisions to Veterans, of health care funding and taxpayer support of that funding.

Ms. Cancio Johnson asserted that costs are out of control with Medicaid currently thirty percent of the budget and rising. She contended that putting more money into the system will not necessarily improve outcomes. Ms. Cancio Johnson maintained that more transparency is needed and noted her continued disappointment regarding the hospital industry and their lack of participation in the Commission. She also indicated her pride in the Commission members despite comments that have been made about the lack of health care experience attributed to the members. Ms. Cancio Johnson noted that Jackson Memorial was in financial trouble for several years until a banker, Mr. Carlos Migoya took control and has begun to turn the facility around financially.

Mr. Eugene Lamb indicated that the costs of health care in our hospital facilities funded through taxpayer contributions need to be spent in a wiser manner. Ms. Sam Seevers echoed Dr. Smith's sentiment that the Commission needed to simplify the information it was receiving into a consumable form. She asserted that Governor Scott was very smart to put together a group with no knowledge of health care, other than Dr. Rosenberg, to look at the issue with a fresh perspective.

Chair Beruff also noted the lack of cooperation from the hospitals and the lack of perceived transparency from them. He indicated that the Commission needs their cooperation in order to have an informed conversation.

Vice Chair Kuntz observed that the public commentators from previous meetings are looking for the same outcome as the Commission—all Floridians receiving proper coverage and healthcare. He

questioned what incentives exist to keep hospital leadership efficient and how do their contracts address their own efficiency. Vice Chair Kuntz reiterated his belief that the Commission should not lose sight of the issue of Certificate of Need and whether elimination of the program would increase competition. He questioned the logic behind the program—whether any logic exists. He concluded with a reminder of the public comment process for the Commission. General Diehl reminded the Commission about its responsibility to give a voice to the public comments by taking them up the chain.

Secretary Dudek noted that the Agency had sent out a secondary data request to hospitals regarding executive compensation and had received substantive information from Hendry Regional Medical Center, Lakeland Regional Medical Center, Calhoun-Liberty Hospital and Douglas Gardens Hospital. She thanked those hospitals for responding.

Vice Chair Kuntz questioned whether it was that difficult for hospitals to provide compensation information. Secretary Dudek indicated that the Governor's staff was assisting with pulling salary information off facilities' 990s. She also noted that Agency staff was working on compiling FTE information but that Agency data did not include contracted staff. Secretary Dudek stated that included in Commissioner's packets was some LIP information and a letter indicating Florida Hospital Association's stance on and lack of support for the Agency's LIP proposal. She also noted that the author of "Unaccountable", Dr. Marty Makary, will be speaking at the Commission's next meeting in Tampa.

Review of Key Findings: Ryan Fitch, Agency for Health Care Administration's Bureau Chief of Central Services, presented the Commission's seven key findings to date.

#1: *Nearly 70 percent (68.9 percent of all inpatient stays (by volume) in hospitals in Florida during calendar year 2013 were covered from government sources.*

Secretary Dudek noted that this figure does not include commercial insurance policies which are subsidized through the Federal Health Insurance Marketplace or paid by the state and federal government agencies.

Vice Chair Kuntz inquired whether other states have similar percentages in regards to payer mix. Ms. Cancio Johnson inquired whether the Commission could have more information on federal exchanges due to her concern regarding pending Supreme Court case, King vs. Burwell. Mr. Spottswood wants to know where the Medicaid dollars are coming from—federal, state or local government. He would like to see where the entire Medicaid budget comes from broken down between the various sources.

#2: *Hospital facilities that earned at least four percent profit tend to provide significantly less charity care services than hospitals that have negative profit margins.*

Mr. Fitch noted that while the tables looked at profitability, hospitals are not in control of who walks in the hospital's door and whether that patient has the ability to pay for services. He indicated that costs might be a better measure to examine.

Vice Chair Kuntz commented that the findings seem like common sense. He inquired, "what do these inform the Commission on?" He also asked if the Commission could see a hospital with negative profit compared to a similar hospital with a four percent or greater positive profit—for example why is Orlando Health making a considerable profit while UF Health Shands Jacksonville is losing lots of money. He stated if the Commission could start singling out facilities to examine why similar facilities are having different outcomes.

Dr. Rosenberg questioned what the impact was to staff, specifically a CEO, for non-profitable hospitals? He inquired whether there was a way to establish an efficiency ratio through existing data to compare hospitals. Mr. Spottswood stated he would like to pull out a facility with a high Medicaid/charity care percentage of patients that is doing well in comparison to a facility with a similar percentage of Medicaid/charity care patients that is not doing well. General Diehl indicated he would like to find some best practices from profitable hospitals and share with all hospitals. Mr. Lamb asserted the importance of transparency.

#3: *Facilities with the least acuity had some the highest expenses as well as being the least profitable.*

Mr. Fitch noted that if rural hospitals are taken out of the analysis, there are no significant differences in cost between profitable hospitals and those that are not profitable. Vice Chair Kuntz would like some additional language added to all key findings qualifying that just because these findings show that in most instances these circumstances are true, it does not preclude the converse from also being true some of the time. For example, some profitable hospitals served a significant number of Medicaid and charity care patients despite key finding number two.

#4: *Hospitals with lower occupancy percentages are more likely to be less profitable than hospitals with higher occupancy percentages.*

Mr. Fitch indicated that one way to look at the data is through cost per adjusted admission and cost per adjusted day. He noted that when looking at data specific to UF Health Shands Jacksonville, the cost per adjusted day was in-line or below the average for the area, but that cost per adjust admission was higher as the average length of stay was higher.

Vice Chair Kuntz inquired how this phenomena happens? Dr. Rosenberg indicated that the Commission would need to dive into the DRG specific information to notice any trends or that it might be market-specific.

Mr. Spottswood inquired how this finding correlated with Certificate of Need (CON)? Ms. Cancio Johnson indicated that she wanted to know how other states deal with this and do we have any outcome data for CON states vs. non-CON states. Secretary Dudek noted that most states don't collect the same kind or amount of data that Florida does. She indicated that we can look into the correlation in Florida since the state deregulated the addition of acute care beds through the CON process.

Dr. Rosenberg queried whether different payer classes got different treatment—and is there any data on that? Ms. Cancio Johnson asserted that the Commission should be looking into keeping people healthier and therefore staying out of the hospital.

Vice Chair Kuntz requested acute care occupancy by district since the deregulation of beds. Dr. Smith reminded the Commission that there is a seasonality aspect to occupancy that has caused troubles in some areas in regards to bed availability.

Vice Chair Kuntz stated that the best facilities are around sixty percent occupied but he is constantly seeing cranes adding on to hospitals. He would like to know which facilities are adding beds and whether these facilities are profitable or not. He questions whether facilities are choosing to invest profits in new beds that are not needed. Dr. Rosenberg notes that there might be tax incentives to build new beds or wings.

#5: Facilities that are profitable without LIP funding remain profitable with LIP funds; and facilities that have not been profitable without LIP funding remain unprofitable with LIP funding (with five exceptions).

Vice Chair Kuntz inquired whether the graph for Jackson Memorial would have look different five years ago, prior to the CEO and banker's oversight? Ms. Cancio Johnson noted that Jackson Memorial is a success story and that Mr. Migoya had to take on the unions during his oversight. She indicated that she would like to hear from Mr. Migoya at the Commission meeting that will take place in Miami.

Dr. Rosenberg indicated that the Commission should look at the impact of Jackson Memorial on the other providers in Miami-Dade. He notes that UF Health Shands Jacksonville takes care of 50 percent charity care and Medicaid patients, thereby allowing Baptist Medical to be profitable with only a 17 percent provision to the Medicaid and charity care population.

#6: *Hospital profits have trended upward over the past 10 years, with the exception of Government owned hospitals.*

Mr. Spottswood questioned whether a governmental hospital that is being leased to a for-profit company is still considered government owned with regards to the data presented. Vice Chair Kuntz that hospitals are doing better now, despite the great recession, than they were doing at the peak of economic prosperity in 2004.

Mr. Fitch states that he did not know why the trend existed, but it would be a good question to ask hospitals whether the recession helped facilities realize greater efficiencies that are being maintained as the economy bounces back. Mr. Spottswood would like to have clarification on funding sources since 2004 to present and whether the increased profits are revenue based or cost controls. Mr. Lamb questioned whether government hospitals are really that different than other hospitals.

#7: *Case Mix Index is an important factor for analysis purposes as a variable to "level the playing field".*

At the conclusion of the review of key findings, Ms. Cancio Johnson indicated that she would like to add a key finding regarding average amount of revenue collected as it pertains to the charge by payer type,

especially Medicaid. Vice Chair Kuntz asserts his concern about using averages for all these key findings as the Commission runs the risk of jumping to conclusions.

Dr. Rosenberg notes that hospital reimbursement is not like the business world and other business models since Medicare truly sets the rate in hospital reimbursement. He maintains that hospital reimbursement terminology is not intuitive—self-pay does not really mean someone is paying the whole bill themselves, it typically means the hospital will receive no reimbursement for the services. Dr. Rosenberg notes hospital accounting and reimbursement is not really understood except by a very small proportion of the population, those in the industry.

Ms. Cancio Johnson contends that hospitals should have to disclose costs and does not understand why there is such a lack of transparency in the industry. She questions why the industry isn't regulated and that the billing side is completely shrouded. Ms. Cancio Johnson notes that menus display their prices, why shouldn't a hospital? Dr. Rosenberg indicates that due to the lack of price sensitivity since the consumer is not truly paying, comparison shopping does not truly exist for hospitals in the business world context.

Vice Chair Kuntz states his satisfaction with the key findings. He would like to see something added regarding CON, about the number of states that currently have or do not have a certificate of need program. Mr. Lamb noted that he would like more information on Certificate of Need. General Diehl would like to add some key findings about accessibility and quality of care.

Mr. Spottswood noted that he would like to add some more detail to the first key finding, particularly a breakdown of how much funding is coming from federal, state and local sources. He would also like to expand on key finding six. Mr. Spottswood indicated that a key finding, or the first key finding should be that the Commission is committed to giving access and quality of care to the citizens of Florida.

Chair Beruff would like to know costs for particular procedures as hospitals should be responsible for providing transparency. He would also like staffing levels from 2009 to present. Secretary Dudek noted that the Agency was working on that data for future meetings.

Spotlight on Transparency Data Discussion: Mr. Ryan Fitch continued his presentation with a Florida Hospital Uniform Reporting System (FHURS) data discussion and guide sheet. Vice Chair Kuntz would like clarification on the differences between for profit and not-for-profit hospitals other than taxing benefits—is there a balancing factor? He likens this distinction of banks vs. credit unions where credit unions have all of the benefits. Vice Chair Kuntz would also like to know if not-for-profit facilities are receiving a greater amount of governmental assistance than for-profit facilities. Ms. Cancio Johnson would like to examine the payer mixes of not-for-profit facilities versus for profit facilities.

Dr. Rosenberg would like clarification on bad debt and would like to know the benefits of overstating bad debt. Vice Chair Kuntz notes that legitimate bad debt can be written off from profitability for tax purposes but he doesn't understand hospital accounting practices. Mr. Fitch indicates that there is no economic incentive to reduce charges but that costs are not overinflated.

Mr. Spottswood wanted further information on the Public Medical Assistance Trust Fund (PMATF) assessment—how much is it and where does it go. Mr. Fitch indicated that it is 1.5 percent of inpatient and one percent of outpatient revenues flow back to Medicaid through the assessment.

Vice Chair Kuntz notes that he would like to break out operating expenses by facility and analyze.

Mr. Fitch then presented financial data specific to the Tampa market to help the Commission decide on whom to invite to present at the next Commission meeting. Dr. Smith maintained that it was important for the Commission to set some expectations on the hospital presentations.

Ms. Cancio Johnson asked when 2014 financial data would be available to the Commission. Dr. Rosenberg queried whether there was statistical data that facility size might change Cost per Adjusted Admission.

Vice Chair Kuntz asked Mr. Fitch to postulate a hypothesis to submit to the Commission on the reasons why the best hospitals are doing so much better than the worst hospitals and draw conclusions for the Commission. Mr. Fitch noted that the 2011 Commission on Review of Taxpayer Funded Hospital Districts found that there was considerable diversity among the hospitals and was unable to find any correlation as to why one facility functioned better or worse than another facility through statistical analysis.

Dr. Rosenberg questioned whether redirecting Medicaid and charity care patients to only profitable facilities completely change the landscape of a medical market? Mr. Spottswood indicated that taxpayer funds should not be directed towards inefficient facilities but that the goal was for quality and successful outcomes at better costs. He asked Mr. Fitch whether quality was completely subjective? Mr. Fitch indicated that quality was not quantifiable with the data he collected. Secretary Dudek noted that quality measures and indicators would be explored in subsequent meetings.

Mr. Fitch presented EBITDA (earnings before interest, taxes, depreciation and amortization) data on Tampa area facilities. Dr. Smith indicated that there should be some sort of efficiency ratio that can be developed from the EBITDA data on a per bed basis. Mr. Fitch suggested it should be developed from cost per adjusted admission.

Vice Chair Kuntz noted that the Commission needed to decide on some facilities to invite to the next meeting. Mr. Spottswood indicated that he would like to make sure to invite some facilities that receive state funding and perhaps a representative from the group that sent in a letter opposing the Agency's LIP proposal.[1] General Diehl indicated that he would like to have an industry expert that is currently

[1] A letter from the Florida Hospital Association (FHA) dated June 1, 2015 to Ms. Wachino at the Centers for Medicare and Medicaid Services, was included to Commission members and on the website. The letter expressed FHA's "strong concerns regarding the new AHCA proposal's impact on patient access and its ability to effectively raise funds for the state share of the Medicaid program."

independent and not tied to any facility. Vice Chair Kuntz suggested that Secretary Dudek come up with and invite facilities on behalf of the Commission.

LIP Presentation: Ms. Stacey Lampkin, Assistant Deputy Secretary for Medicaid Finance and Analytics, presented information on the Agency's proposal to the Centers of Medicare and Medicaid Services which includes one billion in funds for fiscal year 2015/2016 and approximately $600 million for fiscal year 2016/2017, consistent with the CMS letter received May 21st. She clarified that the proposal would include voluntary IGT contributions which would produce a total computable pool of $2.3 billion Ms. Lampkin noted that the proposal includes $200 million in transitional payments as the proposed change of distribution has an implication to individual facilities. She discussed spreadsheet with projections of these transitional payments, which is available on the Commission website. Ms. Lampkin stated that participation requirements would be in place for receipt of these funds.

Ms. Cancio Johnson wanted to know if the Commission could be provided with a breakdown of the amount of money that is going to total patient care. Mr. Spottswood would like to be supplied with a flow of funds chart—knowing from start to finish who touches these funds and how do they distribute them. He would also like to know the cost savings through the managed care plans to the tax payers.

General Diehl would like to see a historical progression of LIP funds from 2006 to present. Ms. Lampkin noted that FY 2014-2015 was the only year that the state received more than one billion. She stated that the reason for this was a reclassification of dollars elsewhere in the system in response to managed care's rollout. General Diehl noted that under the proposed plan, some facilities will have significant losses of LIP payments.

Dr. Rosenberg inquired whether there are any resources that can be utilized in order to distribute funds to facilities that are the most efficient. He asked what incentives are currently in place. Dr. Rosenberg also wanted to know how a managed care plan becomes profitable.

David Rogers, Assistant Deputy Secretary for Medicaid Operations, spoke about the Statewide Medicaid Managed Care program and that it includes increasing quality of care. He stated that 44 performance measures are in the Medicaid Managed Care contract based on HEDIS (Healthcare Effectiveness Data and Information Set) measures. He gave several examples of what the plans and Agency were doing on this front, including pediatric oral care, inappropriate emergency room visits and early elective delivery practices.

Ms. Lampkin concluded that presentation by stating that the program goals related to hospitals can be incorporated into managed care rate-setting, incentivizing managed care plans to work with hospitals to achieve those goals. She provided the example of reducing the rate of cesarean section deliveries stating that capitation rate assumptions around inpatient expenditures can incorporate a lower rate of cesarean section deliveries, provided that it is reasonably achievable.

Commission Member Discussion: Vice Chair Kuntz noted that the Commission received no public speaker cards. Surgeon General Armstrong stated that there are continuing themes on revenue sources

and incentives emerging from the Commission meetings as well as patient transparency for outcomes that matter.

Secretary Dudek indicated that the next meeting will be held in Tampa on June 17th at 8 a.m. with the venue to be announced soon and that the Agency would invite no more than four hospitals to present.

Meeting Adjourn: The meeting adjourned at 12:02 p.m.

Tampa General Hospital

1) Potentially Preventable Readmission Rate: 6.143795%. Percent of admissions that are potentially preventable readmissions depending on the quality of care

   Potentially Preventable Readmission (PPRs) identify return hospitalizations that may have resulted from the process of care and treatment (readmission for a surgical wound infection) or lack of post admission follow-up (prescription not filled) rather than unrelated events that occur post admission.

2) Serious Complications Rate (Infection/Injury): 1.65 (index of 1 is average rate of serious complications across all hospitals)

   A complication that results when a patient is admitted to a hospital for one medical problem and develops a serious injury or infection that may result in death. These events can be prevented if hospitals follow best practices for treatment.

3) HCAHPS 5 Star Patient Satisfaction Survey: 3 Stars

   The scale is 1-5 with 1 being the worst patient experience and 5 being the best. Enables consumer to more quickly access patient experience of care information that is provided.

4) Patient Cost Per Procedure- The state does not currently collect data to determine actual payments between insurers and hospitals. The construction or establishment of multi-payer claims data base would help to bring transparency to this issue.

5) Emergency Room Wait Time for Diagnostic Evaluation: 49 minutes

   The amount of time it takes to see a qualified medical professional and receive a diagnostic evaluation.

6) Physician/Nursing Quality- Quality is measured in part by patient satisfaction surveys and through the submission of adverse incident reports as defined in s. 395.0197, F. S. Hospitals are required to submit incident reports related to events that have resulted in death or serious injury within 15 calendar days. Additionally, each hospital is required to submit an annual Adverse Incident Report to the AHCA. These reports are not made available to the public pursuant to s. 119.07 (1), F.S., except in disciplinary proceedings.

Additional Information for Tampa General Hospital (NFP)
CY 2013

Overall Profitability (Total Margin): $68,663,655 (7.2%)

Number of Admissions: 41,113

Case Mix: 1.93

Average Length of Stay: 6.4 days

Number of Emergency Department Visits: 56,170

Cost per Patient: $16,126

Number of FTE Physician Residents: 247.12

FLORIDA HEALTH SCIENCES CENTER, INC.

Consolidated Financial Statements

September 30, 2014 and 2013

(With Independent Auditors' Report Thereon)

FLORIDA HEALTH SCIENCES CENTER, INC.

Table of Contents

KPMG LLP
Suite 1700
100 North Tampa Street
Tampa, FL 33602

Independent Auditors' Report

The Board of Directors
Florida Health Sciences Center, Inc.:

We have audited the accompanying consolidated financial statements of Florida Health Sciences Center, Inc. (the Center), which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations and changes in unrestricted net assets, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly in all material respects, the consolidated financial position of Florida Health Sciences Center, Inc. as of September 30, 2014 and 2013, and the changes in its net assets, and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP

December 18, 2014
Certified Public Accountants

FLORIDA HEALTH SCIENCES CENTER, INC.

Consolidated Balance Sheets

September 30, 2014 and 2013

Assets	2014	2013
Current assets:		
Cash and cash equivalents	$ 90,518,288	94,027,571
Short-term investments	30,101,630	8,048,436
Current portion of assets limited as to use	14,168,561	9,380,161
Patient accounts receivable, net of allowance for uncollectible accounts of approximately $138,821,000 in 2014 and $117,516,000 in 2013	121,034,857	140,200,302
Inventories	20,553,796	20,167,792
Prepaid expenses and other current assets	40,290,257	10,307,874
Total current assets	316,667,389	282,132,136
Assets limited as to use, less current portion	719,742,375	638,951,860
Property and equipment, net	453,897,496	449,020,218
Other assets	8,646,499	9,412,533
	$ 1,498,953,759	1,379,516,747
Liabilities and Net Assets		
Current liabilities:		
Accounts payable	$ 107,591,965	83,299,886
Accrued expenses	102,201,044	92,638,304
Current installments of long-term debt	7,275,879	4,158,459
Estimated third-party payor settlements	90,903,772	84,071,944
Total current liabilities	307,972,660	264,168,593
Long-term debt, excluding current installments	389,556,023	396,831,953
Other liabilities	93,518,777	100,006,760
Total liabilities	791,047,460	761,007,306
Net assets:		
Unrestricted	691,556,436	602,195,810
Temporarily restricted	15,439,127	15,410,641
Permanently restricted	910,736	902,990
Total net assets	707,906,299	618,509,441
	$ 1,498,953,759	1,379,516,747

See accompanying notes to consolidated financial statements.

FLORIDA HEALTH SCIENCES CENTER, INC.

Consolidated Statements of Operations and Changes in Unrestricted Net Assets

Years ended September 30, 2014 and 2013

	2014	2013
Unrestricted revenues, gains, and other support:		
Patient service revenue (net of contractual allowances and discounts)	$ 1,068,768,027	1,032,349,371
Provision for bad debts	(59,273,583)	(77,459,331)
Net patient services revenue less provision for bad debts	1,009,494,444	954,890,040
Disproportionate share distributions	23,643,730	23,637,250
Other revenue	47,070,338	40,685,133
Total unrestricted revenues, gains, and other support	1,080,208,512	1,019,212,423
Expenses:		
Salaries and benefits	490,538,942	482,254,873
Medical supplies	234,371,525	218,842,109
Purchased services	90,468,848	75,831,959
Utilities and leases	20,586,848	20,394,701
Insurance	17,517,582	18,578,309
Depreciation and amortization	43,148,593	42,700,335
Professional fees	32,989,876	32,452,548
Interest	16,336,401	18,829,853
Other	83,212,088	76,538,479
Total expenses	1,029,170,703	986,423,166
Operating income	51,037,809	32,789,257
Nonoperating gains (losses):		
Investment return	36,314,322	42,966,485
Other	4,122,732	(7,092,087)
Total nonoperating gains	40,437,054	35,874,398
Revenues, gains, and other support over expenses	91,474,863	68,663,655
Other changes in net assets:		
Net assets released from restrictions used for property and equipment	3,178,175	4,277,067
Pension-related changes other than net periodic pension cost	(5,292,412)	78,600,330
Increase in unrestricted net assets	$ 89,360,626	151,541,052

See accompanying notes to consolidated financial statements.

FLORIDA HEALTH SCIENCES CENTER, INC.

Consolidated Statements of Changes in Net Assets

Years ended September 30, 2014 and 2013

	2014	2013
Unrestricted net assets:		
Revenue, gains, and other support over expenses	$ 91,474,863	68,663,655
Net assets released from restrictions used for property equipment	3,178,175	4,277,067
Pension-related changes other than net periodic pension cost	(5,292,412)	78,600,330
Increase in unrestricted net assets	89,360,626	151,541,052
Temporarily restricted net assets:		
Net assets released from restrictions:		
Used for property and equipment	(3,178,175)	(4,277,067)
Used for operations	(1,535,419)	(1,479,377)
Contributions	3,700,509	3,644,560
Increase in beneficial interest in net assets of Tampa General Hospital Foundation	1,041,571	1,344,767
Increase (decrease) in temporarily restricted net assets	28,486	(767,117)
Permanently restricted net assets:		
Increase in beneficial interest in net assets of Tampa General Hospital Foundation	7,746	52,802
Increase in permanently restricted net assets	7,746	52,802
Increase in net assets	89,396,858	150,826,737
Net assets, beginning of year	618,509,441	467,682,704
Net assets, end of year	$ 707,906,299	618,509,441

See accompanying notes to consolidated financial statements.

FLORIDA HEALTH SCIENCES CENTER, INC.

Consolidated Statements of Cash Flows

Years ended September 30, 2014 and 2013

	2014	2013
Cash flows from operating activities:		
Increase in net assets	$ 89,396,858	150,826,737
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	43,148,593	42,700,335
Amortization of debt issue costs	265,366	2,204,432
Restricted contributions	(1,870,721)	(2,392,325)
Unrealized losses (gains), net	4,901,801	(22,233,096)
Realized gains	(28,500,305)	(10,279,743)
Provision for bad debts	59,273,583	77,459,331
Pension-related changes other than net periodic pension cost	5,292,413	(78,600,330)
Changes in operating assets and liabilities:		
Patient accounts receivable	(40,108,138)	(80,444,021)
Inventories	(386,004)	447,530
Prepaid expenses and other current assets	(29,942,383)	7,291,013
Accounts payable	17,324,155	5,257,474
Accrued expenses	9,562,740	(1,837,916)
Estimated third-party payor settlements	6,831,828	14,399,425
Other liabilities	(12,948,134)	12,443,797
Net cash provided by operating activities	122,241,652	117,242,643
Cash flows from investing activities:		
Purchases of property and equipment	(40,453,843)	(34,684,741)
Increase in assets limited as to use	(61,980,412)	(107,112,664)
(Increase) decrease in short-term investments, net	(22,053,194)	103,730
Net cash used in investing activities	(124,487,449)	(141,693,675)
Cash flows from financing activities:		
Proceeds from restricted contributions	1,870,721	2,392,325
Proceeds from issuance of long-term debt	—	216,412,697
Payments on long-term debt	(2,990,771)	(188,048,005)
Payments of debt issue costs	(143,436)	(2,129,701)
Net cash (used in) provided by financing activities	(1,263,486)	28,627,316
(Decrease) increase in cash and cash equivalents	(3,509,283)	4,176,284
Cash and cash equivalents at beginning of year	94,027,571	89,851,287
Cash and cash equivalents at end of year	$ 90,518,288	94,027,571
Supplemental cash flow information:		
Cash paid for interest	$ 16,310,430	19,813,027
Accounts payable for property and equipment purchases	10,775,672	3,807,748

See accompanying notes to consolidated financial statements.

(1) Summary of Significant Accounting Policies

(a) Organization and Basis of Presentation

Florida Health Sciences Center, Inc. (the Center), located in Tampa, Florida, is a not-for-profit entity incorporated during 1997 to meet the healthcare needs of the citizens of Hillsborough County and the state of Florida. The Center operates Tampa General Hospital (the Hospital), where it administers a teaching program for interns and residents. On October 1, 1997, control of the operations and all assets and liabilities of the Hospital were transferred from Hillsborough County Hospital Authority (the Authority), a governmental entity, to the Center. The change in control was accomplished through the execution of an agreement between the Authority and the Center, as well as changes granted by the Florida Legislature that provided for the privatization of the Hospital.

In connection with the change in control, the Center entered into a 49-year lease agreement, which can be extended for an additional 49 years, with the Authority to lease the land and buildings on the Davis Islands campus, together with all improvements located thereon, for a nominal annual rental amount of $10. For financial reporting purposes, the fair value of the leased assets of approximately $86,571,000 as of October 1, 1997 was reported as an increase in temporarily restricted net assets for the year ended September 30, 1998, as the leased assets can only be utilized in accordance with the specifications of the lease agreement. During 2014 and 2013, net assets of approximately $1,093,000 and $1,885,000, respectively, were released from restriction, relating to the annual depreciation expense associated with the leased assets.

The Center incorporated Florida Health Sciences Center, Ltd. (the Captive) on May 21, 2010 under the Companies Law of the Cayman Islands and obtained an Unrestricted Class B Insurers License under the provisions of the Cayman Islands Insurance Law. The Captive, a wholly owned subsidiary of the Center, provides professional and general liability coverage to the Center. Tampa General Hospital Foundation (the Foundation) is a related not-for-profit organization, which supports the Center.

In 2010, the Hospital created Tampa General Medical Group (TGMG), a division of the Hospital. TGMG includes physicians that were once part of the Lifelink Transplant Institute. TGMG has grown to include physicians specializing in family practice, cardiology, endocrinology, hepatology (liver disease), internal medicine, nephrology (kidney disease), organ transplantation and surgery. The over 50 physicians that compose TGMG are spread across several locations in the Tampa area. On March 16, 2014, the Center established Tampa General Medical Group, Inc., a corporation organized under the laws of the state of Florida, and a wholly owned subsidiary, for the purpose of holding the operations of TGMG. On June 27, 2014, Tampa General Medical Group, Inc. was granted tax exempt status by the Internal Revenue Service. Tampa General Medical Group, Inc. shall be operated exclusively for charitable purposes, within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended. As of September 30, 2014, Management had not moved the operations of TGMG to Tampa General Medical Group, Inc., and continues to report operations under the Center.

On July 15, 2014, the Center established FHSC Real Property Holding Company, LLC (the Company), a Limited Liability Company organized under the laws of the state of Florida and a wholly owned subsidiary. The Company was organized to hold future use properties and shall be

(Continued)

operated exclusively for charitable purposes, within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended.

The consolidated financial statements of the Center include the operations of the Hospital, the Captive, and the Center's beneficial interest in the net assets of the Foundation. All significant intercompany transactions among those entities have been eliminated during consolidation.

On January 31, 2014, the Center and Adventist Health System Sunbelt Healthcare Corporation (Florida Hospital) established West Central Florida Health Alliance, LLC, a Limited Liability Company organized under the laws of the state of Florida. The Center and Florida Hospital, each, contributed $1,000,000 to West Central Florida Health Alliance, LLC in exchange for a 50% ownership interest. The new partnership will provide Tampa residents with greater access to a spectrum of community services and broaden the geographic footprint of these two healthcare providers. On August 5, 2014, the Center and Florida Hospital established West Florida Health, Inc., a Florida not-for-profit corporation. In October 2014, the Center and Florida Hospital filed Articles of Amendment to give public notice that they are the members of West Florida Health, Inc. In addition, the Center and Florida Hospital have agreed to transfer all assets and liabilities of West Central Florida Health Alliance, LLC to West Florida Health, Inc. As of September 30, 2014, this transfer has not occurred. The Center's distributive share of operating losses, of $181,000 has been included as a non-operating item in the consolidated statements of operations and changes in unrestricted net assets for the year ended September 30, 2014.

On January 31, 2014, the Center established TGH Architecture & Engineering, LLC, a Limited Liability Company organized under the laws of the state of Florida, and a wholly owned subsidiary, for the purpose of holding architectural licenses for the Center. The Company shall be operated exclusively for charitable purposes, within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended.

(b) Mission Statement

Tampa General Hospital is committed to serving all residents of West Central Florida. The Hospital provides comprehensive health services, ranging from wellness and primary care to the most complex specialty care and post-acute services. The Hospital's care reflects a patient-centered approach, and the Hospital's services are delivered in an exceptional manner, with benchmark performance in clinical outcomes, care processes, cost-effectiveness, and patient experience. With the Hospital's unique blend of academic and other healthcare partners, the Hospital plays a special role in supporting medical education and research in its region.

(c) Cash and Cash Equivalents

The Center considers all highly liquid investments with an original maturity of three months or less, when purchased, to be cash equivalents.

(d) Inventories

Inventories consist principally of medical and surgical supplies, drugs, and medicines, and are valued at the lower of cost (first-in, first-out) or market.

(e) Assets Limited as to Use

Assets limited as to use primarily include assets held by independent bank trustees on behalf of the Center under terms of bond indentures and self-insurance trust agreements, and assets designated for capital improvements and employee health benefits, over which the Center retains control and may, at its discretion, subsequently use for other purposes. Amounts required to meet current liabilities have been reclassified to current assets in the consolidated balance sheets.

Earnings on investments include realized and unrealized gains and losses on investments, interest income, and dividends and are included as revenues, gains, and other support over expenses in the consolidated statements of operations and changes in unrestricted net assets, unless the income or loss is restricted by donor or law. Investment income and net gains and losses restricted by donor stipulations are reported as changes in temporarily restricted net assets.

(f) Property and Equipment

Property and equipment, transferred from the Authority on October 1, 1997, was recorded at fair value as determined by an independent appraisal. Other property and equipment acquisitions are recorded at historical cost at the date of acquisition or fair value at the date of donation. Maintenance and repairs are charged to expense as incurred, and improvements are capitalized. Depreciation expense is computed using the straight-line method over the estimated useful lives of the related assets ranging from 3 to 40 years. Equipment under capital leases is amortized using the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization expense in the accompanying consolidated financial statements. Interest cost on borrowed funds during the construction period is capitalized as a component of the cost of the assets.

Gifts of long-lived assets such as land, buildings, or equipment with explicit restrictions that specify how the assets are to be used, and gifts of cash or other assets that must be used to acquire long-lived assets, are reported as restricted support and are recorded at fair value at the time the gift is made. Absent explicit donor stipulations about how long those long-lived assets must be maintained, the Center reports expirations of donor restrictions when the donated or acquired long-lived assets are placed in service.

(g) Other Assets

Other assets include debt issuance costs of approximately $3,243,000 and $3,339,000 as of September 30, 2014 and 2013, respectively. These amounts include costs capitalized in connection with the issuance of the Series 2006, 2012A and a 2013 bank loan. Debt issuance costs are amortized using the effective interest method. Amortization of approximately $265,000 and $285,000 for the years ending September 30, 2014 and 2013, respectively, is included as a component of interest expense. The debt issuance costs are net of accumulated amortization of approximately $1,256,000 and $991,000 as of September 30, 2014 and 2013, respectively.

(h) Bond Discounts and Premiums

Bond discounts and premiums are being amortized using the effective interest method over the life of the related debt. Amortization of bond discounts and premiums of approximately $1,168,000 and

$805,000 for the year ending September 30, 2014 and 2013, respectively, is included as a component of interest expense. Bond premiums of approximately $14,667,000 and $15,836,000 are included with related debt in the consolidated balance sheets as of September 30, 2014 and 2013, respectively.

(i) Impairment of Long-Lived Assets

Management regularly evaluates whether events or changes in circumstances have occurred that could indicate impairment in the value of long-lived assets. There were no impairment losses recorded during the years ended September 30, 2014 and 2013. If there is an indication that the carrying amount of an asset is not recoverable, the Center estimates the projected undiscounted cash flows, from the use and eventual disposition of the asset, excluding interest, to determine whether an impairment loss exists. The impairment loss, if any, would be determined by comparing the historical carrying value of the asset to its estimated fair value.

In addition to consideration of impairment due to the events or changes in circumstances described above, management regularly evaluates the remaining lives of its long-lived assets. If estimates are revised, the carrying value of affected assets is depreciated or amortized over the remaining lives.

(j) Estimated Professional Liability, Workers' Compensation, and Employee Benefits Cost

The Center is self-insured for professional liability, workers' compensation, and employee health benefits. The provision for professional liability, workers' compensation, and employee health benefit claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported, based on evaluation of pending claims and past experience.

(k) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use is limited by donors to a specific time period or purpose. The majority of temporarily restricted net assets are maintained pursuant to the lease agreement with the Authority, whereby the Center must continue to provide specific patient-care related services, continue to serve as a teaching hospital, and continue to provide certain levels of indigent care throughout the 49-year lease term. Permanently restricted net assets have been restricted by donors to be maintained by the Center in perpetuity, the income from which is expendable to support the Center's operations.

(l) Beneficial Interest in Tampa General Hospital Foundation

The Center recognizes its beneficial interest in the net assets of the Foundation. This interest is adjusted to reflect its share of change in the Foundation net assets. The Foundation complies with the provisions of the Florida Uniform Prudent Management of Institutional Funds Act (FUPMIFA).

(m) Patient Accounts Receivable

Receivables are reported net of an allowance for bad debt and contractual adjustment estimates. Although the aggregate amount of receivables may include balances due from patients and third-party payers (including final settlements and appeals), amounts due from third-party payers for retroactive adjustments of items, such as final settlements or appeals, are reported separately in the consolidated financial statements.

For receivables associated with services provided to patients who have third-party coverage, the Center analyzes contractually due amounts and provides an allowance for doubtful accounts, if necessary. For receivables associated with self-pay patients, which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill, the Center records a significant provision for bad debts in the period of service on the basis of its past experience. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Center's allowance for doubtful accounts for private self-pay patients decreased from 82% of self-pay accounts receivable as of September 30, 2013 to 81% of self-pay accounts receivable as of September 30, 2014. In addition, the Center's private self-pay accounts receivable decreased approximately $873,000 from $48.1 million for the year ended September 30, 2013 to $47.2 million for the year ended September 30, 2014. The Center has not changed its charity care or uninsured discount policies during the years ended September 30, 2014 or 2013. The Center does not maintain a material allowance for doubtful accounts from third-party payers, nor did it have significant write-offs from third-party payers.

(n) Net Patient Service Revenue

Net patient service revenue is recorded in the period in which services are provided and is reported at the net realizable amounts from patients, third-party payers, and others for services rendered, including retroactive adjustments under reimbursement agreements with third-party payers. Pass-through amounts are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Laws and regulations governing Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a possibility that recorded estimates associated with these programs will change.

The Center recognizes patient service revenue associated with services provided to patients who have third-party (managed care, Medicare, Medicaid, other) payer coverage on the basis of contractual rates for the services rendered. For under-insured and uninsured patients who do not qualify for charity care, the Center recognizes revenue on the basis of individualized arrangements based on financial need and medical necessity. These arrangements shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation. On the basis of historical experience, a significant portion of the Center's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Center records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized for the years ended September 30, 2014 and 2013 from these major payer sources are as follows:

	2014	2013
Managed care	$ 447,606,680	410,911,823
Medicare	348,474,166	352,378,575
Medicaid	182,181,696	179,904,997
Other	86,255,850	83,943,768
Self-pay	4,249,635	5,210,208
	$ 1,068,768,027	1,032,349,371

(o) Electronic Health Record Incentive Program

The Centers for Medicare & Medicaid Services (CMS) have implemented provisions of the American Recovery and Reinvestment Act of 2009 that provide incentive payments for the meaningful use of certified electronic health records (EHR) technology. CMS has defined meaningful use as meeting certain objectives and clinical quality measures based on current and updated technology capabilities over predetermined reporting periods as established by CMS. The Medicare EHR incentive program provides annual incentive payments to eligible professionals, eligible hospitals, and critical access hospitals, as defined, that are meaningful users of certified EHR technology. The Medicaid EHR incentive program provides annual incentive payments to eligible professionals and hospitals for efforts to adopt, implement, upgrade and meaningfully use certified EHR technology. The Center utilizes a grant accounting model to recognize EHR incentive revenues. The Center records EHR incentive revenue ratably throughout the incentive reporting period when it is reasonably assured that it will meet the meaningful use objectives for the required reporting period and that the grants will be received. The EHR reporting period for hospitals is based on the federal fiscal year, which coincides with the Center's fiscal year of October 1 through September 30. The reporting period for eligible professionals is based on the calendar year. The Center believes that it and its eligible professionals that met meaningful use objectives in the fiscal year ended September 30, 2013 have also met those objectives in the fiscal year ended September 30, 2014. EHR incentive revenues were approximately $1,800,000 and $4,600,000 for the fiscal years ended September 30, 2014 and 2013, and are included in other revenues in the accompanying consolidated statements of operations and changes in unrestricted net assets.

(Continued)

(p) Non-operating Gains and Losses and Revenue, Gains, and Other Support over Expenses

Activities deemed by the Center to be a provision of healthcare services are reported as unrestricted revenues, gains and other support, and expenses. Other activities that are peripheral to providing healthcare services are reported as nonoperating gains and losses.

The consolidated statements of operations and changes in unrestricted net assets include revenue, gains, and other support over expenses. Changes in unrestricted net assets that are excluded from revenue, gains, and other support over expenses are consistent with industry practice. Other changes in unrestricted net assets consist primarily of pension liability adjustments and contributions of long-lived assets, if any.

(q) Disproportionate Share Distributions

The State of Florida Agency for Health Care Administration distributes low-income pool and disproportionate share payments to the Center based on its indigent care service level. The Center's policy is to recognize these distributions as revenue when amounts are due and collection is reasonably assured. The receipt of any additional distributions is contingent upon the continued support by the Florida State Legislature.

(r) Charity Care

The Center provides care to patients who meet certain criteria by reference to established policy threshold. Because the Center does not pursue collection of amounts determined to qualify as charity care, these amounts are not reported as revenue. Partial payments to which the Center is entitled from Medicaid, public assistance, and other programs on behalf of patients that meet the Center's charity care criteria are reported as net patient service revenue.

(s) Income Taxes

The Center has been recognized by the Internal Revenue Service as a tax-exempt organization described in Section 501(c)(3) of the Internal Revenue Code. Accordingly, income earned in the furtherance of the Center's tax-exempt purpose is exempt from federal and state income taxes. Taxes are not levied in the Cayman Islands for income, profit, capital, or capital gains generated by Florida Health Sciences Center, Ltd.

The Center applies Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 740, *Income Taxes*, which clarifies the accounting for uncertainty in income tax positions and provides guidance when tax positions are recognized in an entity's financial statements and how the value of these positions are determined.

Accounting principles generally accepted in the United States of America require management to evaluate tax positions taken by the Center and recognize a tax liability (or asset) if the Center has taken an uncertain position that more likely than not would not be sustainable upon examination by the Internal Revenue Service. Management has analyzed the tax positions taken by the Center, and has concluded that as of September 30, 2014 and 2013, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the consolidated financial statements. The Center is subject to routine audits by taxing jurisdictions;

however, there are currently no audits for any tax periods in progress. Management believes it is no longer subject to income tax examinations for years prior to 2008.

(t) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and the accompanying notes. Actual results could differ from those estimates.

(u) Reclassification

Certain 2013 amounts have been reclassified to conform to the 2014 consolidated financial statement presentation.

(2) Net Patient Service Revenue

The Center has agreements with third-party payers that provide for payments to the Center at amounts different from its established rates. The most significant third-party payers to the Center are the Medicare and Medicaid programs, which account for approximately 50% and 51%, respectively, of the Center's net patient services revenue for both the years ended September 30, 2014 and 2013. A summary of the payment arrangements with major third-party payers is as follows:

(a) Medicare

Inpatient acute care services rendered to Medicare program beneficiaries are paid on a prospectively determined rate per discharge based on the Medicare Severity Diagnosis-related Group (MSDRG) assigned to the patient. Commercial insurers, which operate as Medicare Advantage Plans, generally follow the traditional Medicare MSDRG payment methodology. Defined organ acquisition and graduate medical education costs related to Medicare beneficiaries are paid based on a cost reimbursement methodology, subject to certain limits and regulatory guidelines. The majority of outpatient services are paid on prospectively determined rates per occurrence based on the ambulatory payment classification assigned to the service provided. The Center also receives a disproportionate share payment from Medicare included in its MSDRG payment, based on its level of Medicaid patient volume and low income Medicare beneficiaries.

The Center receives a final settlement for cost reimbursable and pass-through items after submission of its annual cost reports and audits thereof by the Medicare fiscal intermediary. A Medicare final settlement has been determined for all years up to and including 2006. Differences between estimated provisions for cost report settlements and final settlements amounts are reflected as net patient services revenue in the fiscal year the cost reports are considered finalized. Changes in such estimates related to prior cost reporting periods resulted in an increase in net patient services revenue of approximately $3,941,000 and $12,572,000 for the years ended September 30, 2014 and 2013, respectively.

(b) Medicaid

Historically, inpatient and outpatient services rendered to Florida Medicaid program beneficiaries were paid under a cost reimbursement methodology, subject to certain limits. Beginning on July 1,

2013, the Florida Legislature mandated a new inpatient payment methodology utilizing the All-Patient Refined Diagnosis Related Group (APR-DRG). The methodology, which is utilized by most state Medicaid programs, includes severity of illness information in a set of refined DRGs. In addition, the Florida Legislature mandated that the majority of Florida Medicaid beneficiaries be transitioned to Statewide Medicaid Managed Care (SMMC) beginning on June 1, 2014. Because certain populations will be carved out of SMMC, the Center expects that two-thirds of its Medicaid reimbursement will come from SMMC once the transition is complete. The Center continues to be paid for outpatient services on a cost-based rate that reimburses per occasion of service. In general, Medicaid Managed Care Plans will utilize the same payment methodology as traditional Medicaid for reimbursement of inpatient and outpatient services. The Center continues its submission of annual cost reports, which are utilized to set outpatient rates and are audited by the Medicaid fiscal intermediary.

(3) Charity Care

The Center provides necessary medical care regardless of the patient's ability to pay for services under its charity care policy. Qualification for charity care is based on the current Federal Poverty Income Guidelines (FPG). Underinsured and uninsured patients, who do not meet charity guidelines, may qualify for discounted care. Charity or discount consideration is available only after all third party reimbursement and government sources have been exhausted. Excessive assets or medical expenses may be factored as part of the charity or discount evaluation. The Center ensures that financial counseling communication is clear, concise, and considerate of the patient and family members. In addition, regulatory changes that may have the potential to alter charity classifications are monitored and incorporated into the policy, as necessary.

The Center maintains records to identify and monitor the level of charity care. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. The following measures the level of charity care and other community benefits, as defined, at estimated costs for the years ended September 30, 2014 and 2013:

	2014	2013
Traditional charity care	$ 41,686,000	52,013,000
Unreimbursed Medicaid and Medicaid HMO	22,112,000	27,075,000
Unreimbursed Hillsborough County Health Plan	21,774,000	19,750,000
	$ 85,572,000	98,838,000
As a percentage of operating expenses	8%	10%

(Continued)

(4) Concentration of Credit Risk of Net Accounts Receivable

The Center grants credit without collateral to its patients, most of who are local residents and are insured under third-party payer agreements. The mix of receivables from patients and third-party payers as of September 30 is as follows:

	2014	2013
Managed care	47%	48%
Medicare	25	22
Medicaid	6	10
Other	22	20
	100%	100%

The credit risk in other payers is limited due to the large number of insurance companies that provide payments for services.

(Continued)

(5) Assets Limited as to Use and Short–Term Investments

Assets limited as to use as of September 30, 2014 and 2013, at fair value, are as follows:

	2014	2013
Internally designated for capital improvements and employee health benefits:		
Cash and cash equivalents	$ 37,991,035	40,545,336
Equities securities:		
Domestic stocks	280,147,632	223,698,122
Global stocks	39,480,062	36,562,466
Fixed income securities:		
Government obligations	80,561,574	43,786,466
Corporate bonds	186,092,226	167,230,730
Beneficial interest in Tampa General Hospital Foundation	7,597,344	6,548,026
Total internally designated for capital improvements and employee health benefits	631,869,873	518,371,146
Joint ventures:		
West Central Florida Health Alliance, Inc.	818,743	—
Held by trustee under malpractice self-insurance arrangement:		
Cash and cash equivalents	9,965,086	14,343,288
Municipal bonds	34,645,761	43,986,765
Mutual funds	25,366,323	22,236,993
Total held by trustee under malpractice self-insurance arrangement	69,977,170	80,567,046
Held by trustee under bond indentures:		
Cash and cash equivalents	31,245,150	49,393,829
Total held by trustee under bond indentures	31,245,150	49,393,829
Assets limited to use	733,910,936	648,332,021
Amount required to meet current obligations	(14,168,561)	(9,380,161)
Assets limited to use, less current portion	$ 719,742,375	638,951,860

Short-term investments, stated at fair value, consist of the following as of September 30, 2014 and 2013:

	2014	2013
Cash and cash equivalents	$ 25,042,454	3,041,666
Government bonds	5,059,176	5,006,770
	$ 30,101,630	8,048,436

(Continued)

Investment income and gains and losses on assets limited as to use, cash equivalents and other investments comprise the following for the years ended September 30, 2014 and 2013:

	2014	2013
Other revenue:		
Interest income	$ 2,139,941	3,222,027
Net realized (losses) gains on sale of investments, net	(39,965)	172,953
Unrealized gains on trading investments, net	2,170,605	1,433,425
Total	4,270,581	4,828,405
Nonoperating gains:		
Interest income and dividends	14,846,458	12,060,024
Net realized gains on sale of investments, net	28,540,270	10,106,790
Unrealized (losses) gains on trading investments, net	(7,072,406)	20,799,671
Total	36,314,322	42,966,485
Total investment return	$ 40,584,903	47,794,890

(6) Fair Value Measurements

FASB ASC Topic 820, *Fair Value Measurement*, defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants on the measurement date. FASB ASC Topic 820 requires investments to be grouped into three categories based on certain criteria as noted below:

- **Level 1**: Fair value is determined by using quoted prices for identical assets or liabilities in active markets.
- **Level 2**: Fair value is determined by using other than quoted prices that are observable or corroborated for the asset by other independently verifiable market data (e.g., quoted prices for identical assets in inactive markets, quoted prices for similar assets in active markets, observable inputs other than quoted prices, and inputs derived principally from or corroborated by observable market data by correlation or other means).
- **Level 3**: Fair value is determined by using inputs based on management assumptions that are not directly observable.

Following is a description of the valuation methodologies used for significant assets measured at fair value at September 30, 2014:

Cash and cash equivalents: The carrying amounts reported in the consolidated balance sheets approximate the fair value because of the short maturities of these instruments.

Investments: Valued at the closing price reported on the active market on which the individual securities are traded, or valued based on quoted prices for similar assets.

(Continued)

Estimates of fair values are subjective in nature and involve uncertainties and matters of significant judgment and, therefore, cannot be determined with precision. Changes in assumptions could affect the estimates.

The following tables summarize the fair values of the Center's significant financial assets and liabilities as of September 30, 2014 and 2013:

		September 30, 2014	Fair value measurement at reporting date	
			Level 1	Level 2
Cash and cash equivalents	$	90,518,288	90,518,288	—
Short-term investments:				
Cash and cash equivalents		25,042,454	25,042,454	—
Government bonds		5,059,176	5,059,176	—
Assets limited to use:				
Cash and cash equivalents		79,201,271	79,201,271	—
Equity income securities:				
Domestic stocks		280,147,632	280,147,632	—
Global stocks		39,480,062	39,480,062	—
Mutual funds		25,366,323	25,366,323	—
Fixed income securities:				
Government obligations		80,561,574	80,561,574	—
Corporate bonds		186,092,226	—	186,092,226
Municipal bonds		34,645,761	—	34,645,761
Beneficial interest in Tampa General Hospital Foundation		7,597,344	—	7,597,344
Investment in joint venture		818,743	—	818,743
		733,910,936	504,756,862	229,154,074
Total	$	854,530,854	625,376,780	229,154,074

(Continued)

	September 30, 2013	Fair value measurement at reporting date	
		Level 1	Level 2
Cash and cash equivalents	$ 94,027,571	94,027,571	—
Short-term investments:			
Cash and cash equivalents	3,041,666	3,041,666	—
Government bonds	5,006,770	5,006,770	—
Assets limited to use:			
Cash and cash equivalents	104,282,453	104,282,453	—
Equity income securities:			
Domestic stocks	223,698,122	223,698,122	—
Global stocks	36,562,466	36,562,466	—
Mutual funds	22,236,993	22,236,993	—
Fixed income securities:			
Government obligations	43,786,466	43,786,466	—
Corporate bonds	167,230,730	—	167,230,730
Municipal bonds	43,986,765	—	43,986,765
Beneficial interest in Tampa General Hospital Foundation	6,548,026	—	6,548,026
	648,332,021	430,566,500	217,765,521
Total	$ 750,408,028	532,642,507	217,765,521

There were no transfers of financial assets or liabilities between Level 1 and Level 2 during the years ended September 30, 2014 and 2013. There were no investments classified as Level 3 during the years ended September 30, 2014 and 2013.

(Continued)

(7) Long-Term Debt

Long-term debt consists of the following:

	2014	2013
Series 2006 Bonds, net of unamortized premium of $3,162,980 and $3,442,560 as of September 30, 2014 and 2013, respectively, maturing in various amounts through October 1, 2041, with stated rates of 4% to 5.25%	$ 181,492,980	182,852,560
Series 2012A Bonds, net of unamortized premium of $11,504,385 and $12,392,542 as of September 30, 2014 and 2013, respectively, maturing in various amounts through October 1, 2043, with stated rates of 3% to 5%	177,994,385	178,882,542
2013 bank loan, maturing in various amounts through October 1, 2024 at a stated interest rate of 2.57%	37,020,000	37,020,000
Note payable, due in monthly installments through 2015 at a stated rate of interest of 3.25%, collateralized by software	324,537	2,235,310
Total long-term debt	396,831,902	400,990,412
Less current installments	(7,275,879)	(4,158,459)
Long-term debt, excluding current installments	$ 389,556,023	396,831,953

The fair value of long-term debt was approximately $399,053,000 and $376,508,000 as of September 30, 2014 and 2013, respectively.

On September 28, 2006, the Hillsborough County Industrial Authority (Florida) issued $185,000,000 aggregate principal amounts of tax-exempt Hospital Revenue Refunding Bonds (2006 Bonds). Proceeds of the 2006 Bonds were utilized for the expansion, improvement, and further equipping of the Hospital's healthcare facilities. The 2006 Bonds contain various covenants, including but not limited to the maintenance of a minimum debt service coverage ratio and provides that certain funds be established with a trustee bank (note 5). Management believes the Center is in compliance with such covenants at September 30, 2014.

On February 28, 2013, the Hillsborough County Industrial Authority (Florida) issued $166,490,000 aggregate principle amounts of tax-exempt Hospital Revenue Refunding Bonds (2012A Bonds). A portion of the proceeds of the 2012A Bonds was used to purchase and redeem all of the Hospital's outstanding 2003B Bonds and a portion of the Hospital's outstanding Series 2003A Bonds. This transaction resulted in a loss on early extinguishment of debt of approximately $5,958,000 and is included in other non-operating gains (losses) on the consolidated statements of operations and changes in unrestricted net assets. The remaining proceeds of the 2012A Bonds will be utilized for the expansion, improvement and further equipping of the healthcare facilities. The 2012A Bonds contain various covenants, including, but not limited to, the maintenance of a minimum debt service coverage ratio and provides that certain funds be established with a trustee bank (note 5). Management believes the Center is in compliance with such covenants at September 30, 2014.

(Continued)

On September 19, 2013, the Hillsborough County Industrial Development Authority (Florida), Florida Health Sciences Center, Inc. and PNC Bank N.A. entered into a Loan Agreement (2013 bank loan) in the amount of $37,020,000 to provide for the refunding of the remaining outstanding principal of the Series 2003A Bonds. This transaction resulted in a loss on early extinguishment of debt of approximately $834,000 and is included as a component of other non-operating gains (losses) on the consolidated statements of operations and changes in unrestricted net assets. The 2013 bank loan contains various covenants, including, but not limited to, the maintenance of a minimum debt service coverage ratio. Management believes the Center is in compliance with such covenants at September 30, 2014.

The 2006 and 2012A Bonds are secured solely by a pledge of and a security interest in the revenue of the Center. Such pledge and security interest have been assigned to a bank trustee. Stated interest rates on the 2006 Bonds range from 4% to 5.25%, with an effective rate of 5.01% at September 30, 2014, and maturities through October 1, 2041. Except for $10,215,000 of serial bonds maturing prior to October 1, 2017, the 2006 Bonds are subject to mandatory redemption by the Center beginning October 1, 2017 at par plus accrued interest. Stated interest rates on the 2012A Bonds range from 3% to 5% with an effective rate of 4.6% at September 30, 2014, and maturities through October 1, 2043. Except for $21,180,000 of serial bonds maturing prior to October 1, 2028, the 2012A Bonds are subject to mandatory redemption by the Center beginning October 1, 2028 at par plus accrued interest. Stated interest rates on the 2013 bank loan are set at 2.57% with an effective rate of 2.43% at September 30, 2014, and maturities to October 1, 2024.

Scheduled maturities of long-term debt as of September 30, 2014 are as follows:

Year ending September 30:	
2015	$ 6,214,537
2016	9,544,000
2017	6,109,000
2018	6,297,000
2019	6,506,000
Thereafter	347,494,000
Long-term debt, excluding unamortized premiums (discounts)	382,164,537
Unamortized premium	14,667,365
Long-term debt, including unamortized premiums (discounts)	$ 396,831,902

(Continued)

(8) Property and Equipment

Property and equipment consist of the following as of September 30, 2014 and 2013:

	2014	2013
Land	$ 46,639,634	46,639,634
Land improvements, buildings, and fixed equipment	460,634,231	442,493,449
Major moveable equipment	299,919,982	271,977,635
Other equipment	8,038,217	7,777,729
Total property and equipment	815,232,064	768,888,447
Accumulated depreciation and amortization	(388,838,960)	(346,295,972)
Total property and equipment less depreciation and amortization	426,393,104	422,592,475
Construction in progress	27,504,392	26,427,743
Property and equipment, net	$ 453,897,496	449,020,218

Depreciation expense amounted to $42,544,000 and $42,086,000 during the years ending September 30, 2014 and 2013, respectively.

As of September 30, 2014, the estimated cost to complete construction in progress is approximately $73.3 million.

Interest expense, net of interest income, of approximately $314,000 and $555,000, was capitalized during the years ended September 30, 2014 and 2013, respectively.

(9) Lease Obligations

The Center leases certain medical and other support equipment under operating leases. Rent expense under noncancelable operating leases was approximately $8,344,000 and $7,909,000 for the years ended September 30, 2014 and 2013, respectively. Future minimum lease payments as of September 30, 2014 are as follows:

	Operating leases
Year ending September 30:	
2015	$ 8,506,348
2016	6,241,854
2017	3,119,778
2018	1,638,819
2019 and thereafter	1,079,282
Total leases	$ 20,586,081

(Continued)

The Center does not have any capital leases outstanding as of September 30, 2014.

(10) Pension and Other Postretirement Benefits

(a) Retirement Plan

The Center established the Florida Health Sciences Center, Inc. Retirement Plan (the Plan), which became effective January 1, 1998. The Plan is a noncontributory, single employer, cash balance defined benefit pension plan.

All employees are eligible to participate in the Plan as of the beginning of the month following the later of the employee's attainment of age 21 and the completion of one year of service (i.e., generally a plan year during which the employee completes 1,000 hours of service).

The Plan provides retirement, disability, and death benefits to plan members and beneficiaries. Furthermore, the Plan provides a health insurance subsidy to participants who had 20 years of service with the Florida Retirement System as of December 31, 1996. This subsidy is a monthly supplemental payment that a participant may be eligible to receive if they elect health insurance coverage. The amounts payable by the Plan are reduced by the amount payable by the Florida Retirement System for the subsidy. The minimum subsidy is $30 per month and the maximum is $90 per month.

Effective January 1, 2014, due to the introduction of employer matching in its 403b plan, the Center's board of trustees approved an amendment to reduce the contribution schedule. The actuarially computed net periodic pension cost for the Center's Plan for the years ended September 30, 2014 and 2013 included the following components and reflects the impact of the contribution reduction:

		2014	2013
Service cost – benefits earned during the period	$	12,581,943	30,488,947
Interest cost on projected benefit obligation		10,440,276	9,277,995
Expected return on plan assets		(18,679,325)	(16,508,817)
Net amortization and deferral of unrecognized losses		(1,970,287)	4,381,100
Net periodic pension cost	$	2,372,607	27,639,225

(Continued)

The following table sets forth the Plan's funded status and amount recognized in other liabilities in the Center's consolidated balance sheets as of September 30, 2014 and 2013 (using a measurement date of September 30):

	2014	2013
Change in projected benefit obligation:		
Benefit obligation at beginning of year	$ 250,411,706	275,804,834
Service cost	12,581,943	30,488,947
Interest cost	10,440,276	9,277,995
Amendments	—	(20,730,948)
Actuarial (gain) loss	7,568,373	(32,428,155)
Benefits paid	(15,218,928)	(12,000,967)
Projected benefit obligation at end of year	265,783,370	250,411,706
Change in plan assets:		
Fair value of plan assets at beginning of year	248,014,082	206,608,056
Actual return on plan assets	23,015,992	32,345,331
Employer contributions	5,000,000	21,061,662
Benefits paid	(15,218,928)	(12,000,967)
Fair value of plan assets	260,811,146	248,014,082
Funded status and accrued benefit costs	$ (4,972,224)	(2,397,624)

The accumulated benefit obligation for the Plan was approximately $264,799,000 and $248,701,000 as of September 30, 2014 and 2013, respectively.

Weighted average assumptions used to determine projected benefit obligations as of September 30, 2014 and 2013 were as follows:

	2014	2013
Discount rate	4.29%	4.29%
Projected rate of compensation increase	3.00%–8.00%	3.00%–8.00%

The actuarial assumptions used in determining net periodic pension costs for the years ended September 30, 2014 and 2013 are as follows:

	2014	2013
Discount rate	3.82%	3.44%
Projected rate of increase in compensation levels	3.00	3.00
Expected long-term rate of return on plan assets	7.75	7.75

The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual assets categories.

(Continued)

The following are deferred pension costs that have not yet been recognized in periodic pension expense but instead are accrued in unrestricted net assets as of September 30, 2014. Unrecognized actuarial losses represent unexpected changes in the projected benefit obligation and plan assets over time, primarily due to changes in assumed discount rates and investment experience. Unrecognized prior service cost is the impact of changes in plan benefits applied retrospectively to employee service previously rendered. Deferred pension costs are amortized into annual pension expense over the average remaining assumed service period for active employees:

	Net prior service credit	Net actuarial loss	Total
Amounts recognized in unrestricted net assets as of September 30, 2014	$ (17,909,904)	20,306,452	2,396,548
Amounts in net assets to be recognized during the next fiscal year	(15,939,617)	20,306,452	4,366,835

Plan Assets

The weighted average asset allocation of the Center's assets held for pension benefits as of September 30, 2014 and 2013 was as follows:

Asset category	Pension benefits plan assets at September 30 2014	2013
Cash and cash equivalents	6%	7%
Equity securities:		
Domestic stocks	47	59
Global stocks	10	14
Mutual funds	10	—
Fixed income securities:		
U.S. Treasury obligations	9	4
Government agencies	2	1
Corporate bonds	16	15
Total	100%	100%

(Continued)

		September 30, 2014	Fair value measurement at reporting date	
			Level 1	Level 2
Cash and cash equivalents	$	16,387,743	16,387,743	—
Equity securities:				
Domestic stocks		123,502,070	123,502,070	—
Global stocks		25,970,102	25,970,102	—
Mutual funds		26,581,659	—	26,581,659
Fixed income securities:				
Treasury obligations		22,481,234	22,481,234	—
Government obligations		5,428,135	5,428,135	—
Corporate bonds		40,460,203	—	40,460,203
Total	$	260,811,146	193,769,284	67,041,862

		September 30, 2013	Fair value measurement at reporting date	
			Level 1	Level 2
Cash and cash equivalents	$	17,832,507	17,832,507	—
Equity securities:				
Domestic stocks		147,097,883	147,097,883	—
Global stocks		35,940,707	35,940,707	—
Fixed income securities:				
Treasury obligations		8,968,477	8,968,477	—
Government obligations		1,807,061	1,807,061	—
Corporate bonds		36,367,447	—	36,367,447
Total	$	248,014,082	211,646,635	36,367,447

There were no transfers of financial assets or liabilities between Level 1 and Level 2 during the years ended September 30, 2014 and 2013. There were no investments classified as Level 3 during the years ended September 30, 2014 and 2013.

The investment objective of the defined benefit plan is to use prudent and reasonable levels of liquidity and investment risk to produce an investment return that provides for payments of benefits to participants and their beneficiaries. The investment objective also incorporates the financial condition of the plan, future growth of active and retired participants, inflation, and the rate of salary increases. The defined benefit plan's investment committee has selected market-based benchmarks to monitor the performance of the investment strategy and performs periodic reviews of investment performance.

The investment strategy has a current target allocation policy as follows: 75% equities and 25% fixed income and other securities. The expected long-term rate of return on plan assets is determined based primarily on expectations of future returns for the defined benefit plan's investments based on the

target asset allocation. Additionally, the historical returns on comparable equity and fixed income investments are considered in the estimate of the expected long-term rate of return on plan assets.

Cash Flows

The Center does not expect to make any contributions to the Plan in fiscal year 2014.

The benefits expected to be paid in each year from 2015 through 2019 are approximately $15,985,000; $16,321,000; $16,414,000; $17,155,000; and $18,133,000, respectively. The aggregate benefits expected to be paid from 2020 through 2024 are approximately $107,392,000. The expected benefits are based on the same assumptions used to measure the Center's benefit obligations as of September 30, 2014 and include estimated future employee service.

(b) 403b Savings Plan

Effective January 1, 2014, the Center's board of trustees approved an amendment and restatement of its 403(b) Savings Plan document to include a matching contribution equal to the sum of 100% of the first 3% of compensation deferred and 50% of the next 2% of compensation deferred. The original effective date of this plan was December 1, 1999. The Plan was established for the exclusive benefit of the participants and their beneficiaries. All employees are automatically enrolled upon hire for purposes of the elective deferral, unless they opt not to participate. Participants are eligible to receive a matching contribution upon completion of certain service requirements. Contribution expense attributable to this defined contribution plan was approximately $7.9 million for the year ended September 30, 2014.

(c) Supplemental Retirement Plan

Effective January 1, 2002, the Center established the Florida Health Sciences Center, Inc. Supplemental Executive Retirement Plan (SERP). The SERP is a nonqualified defined benefit plan limited to certain management or highly compensated employees as determined by the Center. Upon vesting, the SERP provides participants with deferred compensation annually, based on 60% of the participants' compensation during the highest five complete calendar years out of the last 10 complete calendar years. Certain adjustments are made to the annual benefit based on current and projected years of service and expected benefits payable under the Florida Retirement System, if any, Social Security, and the Florida Health Sciences Center, Inc. Retirement Plan. Only calendar years beginning on or after January 1, 2002 are considered. Vesting is generally effective after a participant completes five years of service with the Center. The SERP also provides for certain death or disability benefits.

The actuarially computed net periodic pension cost for the Center's SERP for the years ended September 30, 2014 and 2013 included the following components (using a measurement date of September 30):

		2014	2013
Service cost – benefits earned during the period	$	1,486,088	1,542,861
Interest cost on projected benefit obligation		520,163	488,595
Net amortization and deferral of unrecognized losses		449,399	807,739
Net periodic pension cost	$	2,455,650	2,839,195

The following table sets forth the SERP's funded status and amount recognized in other liabilities in the Center's consolidated balance sheets as of September 30, 2014 and 2013:

		2014	2013
Change in projected benefit obligation:			
Benefit obligation at beginning of year	$	14,993,877	21,665,520
Service cost		1,486,088	1,542,861
Interest cost		520,163	488,595
Amendments		—	716,518
Actuarial gain (loss)		7,219	(949,211)
Settlements		—	(7,338,621)
Benefits paid		(614,247)	(1,131,785)
Projected benefit obligation at end of year		16,393,100	14,993,877
Fair value of plan assets at end of year		—	—
Funded status and accrued benefit costs	$	(16,393,100)	(14,993,877)

The accumulated benefit obligation for the SERP was approximately $13,131,000 and $11,920,000 as of September 30, 2014 and 2013, respectively.

Weighted average assumptions used to determine projected benefit obligations at September 30, 2014 and 2013 were as follows:

	2014	2013
Discount rate	3.46%	3.46%
Projected rate of compensation increase	3.00%–8.00%	3.00%–8.00%

(Continued)

The actuarial assumptions used in determining net periodic pension costs for the years ended September 30, 2014 and 2013 are as follows:

	2014	2013
Discount rate	3.46%	2.54%–2.77%
Projected rate of increase in compensation levels	3.00%–8.00%	3.00%–8.00%

The following are deferred pension costs, which have not yet been recognized in periodic pension expense but instead are accrued in unrestricted net assets as of September 30, 2014. Unrecognized actuarial losses represent unexpected changes in the projected benefit obligation and plan assets over time, primarily due to changes in assumed discount rates and investment experience. Unrecognized prior service cost is the impact of changes in plan benefits applied retrospectively to employee service previously rendered. Deferred pension costs are amortized into annual pension expense over the average remaining assumed service period for active employees:

	Net prior service cost	Net actuarial loss	Total
Amounts recognized in unrestricted net assets as of September 30, 2014	$ 75,920	373,479	449,399
Amounts in net assets to be recognized during the next fiscal year	75,920	324,807	400,727

Cash Flows

The Center does not expect to make any contributions to the SERP in fiscal year 2015.

The benefits expected to be paid in each year from 2015 through 2019 are approximately $2,450,000; $1,810,000; $439,000; $452,000; and $617,000, respectively. The aggregate benefits expected to be paid in the five years from 2020 through 2024 are approximately $10,462,000. The expected benefits are based on the same assumptions used to measure the Center's benefit obligations at September 30, 2014 and include estimated future employee service.

(d) Other Postretirement Benefits

The Center sponsors a defined benefit postretirement plan, which is intended to provide medical benefits to retirees who were hired prior to January 1, 2001 and had completed 30 or more years of service or who attained age 62 and completed five years of service. In addition, the plan provides benefits to retirees who had completed 20 or more years of service prior to January 1, 1997. The postretirement plan is contributory, with retiree contributions adjusted annually based on the projected average plan cost of the Center's self-insured health benefit program for the year. The Center accrues the cost of providing postretirement benefits during the active service period of the employee.

The components of net periodic postretirement benefit cost for the years ended September 30, 2014 and 2013 are as follows:

		2014	2013
Service cost – benefits attributed to service during the year	$	107,608	121,285
Interest cost on accumulated postretirement benefit obligation		198,104	185,778
Amortization of net gain (loss)		(141,103)	(108,236)
Net periodic postretirement benefit cost	$	164,609	198,827

The following table sets forth the postretirement plan's funded status and amounts recognized in other liabilities in the Center's consolidated balance sheets as of September 30, 2014 and 2013 (measurement date as of September 30):

		2014	2013
Change in accumulated benefit obligation:			
Accumulated benefit obligation at beginning of year	$	3,788,221	4,497,330
Service cost		107,608	121,285
Interest cost		198,104	185,778
Retiree contributions		416,809	458,730
Actuarial loss (gain)		72,405	(732,534)
Benefits paid		(372,717)	(742,368)
Accumulated benefit obligation at end of year		4,210,430	3,788,221
Change in plan assets:			
Employer contribution		(44,092)	283,638
Employee contribution		416,809	458,730
Benefits paid		(372,717)	(742,368)
Fair value of plan assets at end of year		—	—
Funded status and accrued benefit costs	$	(4,210,430)	(3,788,221)

For measurement purposes, an 8.5% and 9.5% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2014 and 2013, respectively, and the rate was assumed to decrease gradually to 5.5% over the subsequent three years and remain at that level thereafter.

The weighted average discount rate used in determining the accumulated postretirement benefit obligation was 4.75% and 5.3% as of September 30, 2014 and 2013, respectively. The weighted average discount rate used in determining the net benefit cost was 5.3% and 4.6% as of September 30, 2014 and 2013, respectively.

(Continued)

The impact of a one percentage point change in assumed healthcare cost trend rates as of September 30, 2014 is as follows:

	1% Increase	1% Decrease
Effect on total of service and interest cost components	$ 52,484	(40,819)
Effect on postretirement benefit obligation	758,939	(140,767)

The following are deferred pension costs that have not yet been recognized in periodic pension expense but instead are accrued in unrestricted net assets as of September 30, 2014. Unrecognized actuarial losses represent unexpected changes in the projected benefit obligation and plan assets over time, primarily due to changes in assumed discount rates and investment experience. Deferred pension costs are amortized into annual pension expense over the average remaining assumed service period for active employees.

Net actuarial gain recognized in unrestricted net assets as of September 30, 2014	$ —
Net actuarial gain to be recognized during the next year	(126,757)

Cash Flows

The Center expects to contribute approximately $332,000 to its postretirement benefit plan in 2015.

The benefits expected to be paid in each year from 2015 through 2019 are approximately $332,000; $322,000; $268,000; $272,000; and $267,000, respectively. The aggregate benefits expected to be paid in the five years from 2020 through 2024 are $1,096,000. The expected benefits are based on the same assumptions used to measure the Center's benefit obligations as of September 30, 2014 and include estimated future employee service.

(11) Commitments and Contingencies

(a) Litigation

During the normal course of business, the Center is involved in litigation with respect to professional liability claims and other matters. In addition, the Center is subject to periodic regulatory investigations. The Center has purchased insurance coverage to minimize its exposure to such risk. This coverage includes property, directors and officers, vehicles, medical malpractice, and general liability. Each policy has its own deductible and/or self-insurance retention. Based on current information, management believes at this time that the results of the litigation and inquiries are not likely to have a material adverse effect on the consolidated financial position and results of the Center.

(b) Professional Liability

The Center insures its professional and general liability on a claims-made basis through a commercial insurance carrier. The Center has secured claims-made coverage continuously from October 1, 1997 through September 30, 2014. The Center has renewed its claims-made policy.

For claims prior to October 1, 1997, the Authority, as an agency or subdivision of the state of Florida, had sovereign immunity in tort actions. Therefore, in accordance with Chapter 768.28, the Center's legal liability was limited by statute to $100,000 per claimant and $200,000 for all claimants per occurrence. Self-insurance retention limits from October 1, 1997 to September 30, 2010 range from $1,000,000 to $5,000,000. On May 21, 2010, the Captive was incorporated to provide excess professional liability and general liability coverage to the Center on a claims–made basis. The Captive's liability under this policy is limited to $80,000,000 per claim and in the aggregate.

The Center has employed independent actuaries to assist management in estimating the ultimate costs, if any, of the settlement of known claims and incidents, as well as unreported incidents that may be asserted, arising from services rendered to patients. Reported amounts for professional liability were approximately $77,565,000 and $82,777,000 as of September 30, 2014 and 2013, respectively, and are included in accrued expenses and other liabilities on the accompanying consolidated balance sheets. The Center records the professional liability based on the actuarially determined expected level. Given the maturity of the plan, the Center believes the expected level is a better estimate of the ultimate outcome than other confidence levels. The expected level is a commonly followed industry practice.

(c) Third Party Reimbursement

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Center is aware of these laws and regulations and, to the best of its knowledge and belief, is in compliance. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs.

(12) Other Funding Sources

The Hospital receives funding from various components of the state of Florida's (the State) Medicaid program, including the Low Income Pool program (LIP) and Medicaid per diem rates. The State's LIP program distributes funding to the Hospital in recognition of the disproportionate level of care provided to indigent patients and to defray some of the costs associated with graduate medical education. The LIP is a federal matching program that provides states with the opportunity to receive additional distributions based upon the difference between Medicaid reimbursement and the amount that would have been received for the same patients using Medicare reimbursement formulas, as defined. Medicaid fee for service is paid based on inpatient per diem and outpatient per line rates and may be adjusted based on annual cost report submissions.

The total funding amounts from the LIP and trauma programs were approximately $23,644,000 and $23,637,000 during the years ended September 30, 2014 and 2013, respectively, and are reported as disproportionate share distributions in the accompanying consolidated statements of operations and changes in unrestricted net assets. Since July 1, 2001, the Hospital has received trauma funding of approximately $3,500,000 per year from Hillsborough County to supplement the Hospital's reimbursement for trauma services rendered to Hillsborough County residents.

(Continued)

Under the terms of an agreement with the Hillsborough County Health Plan, the Hospital is paid for authorized services provided to eligible recipients based on contracted rates. The contract renews on an annual basis and is currently through June 30, 2015. These payments are subject to certain limits (network caps) for each network per contract, including amounts the Hospital must reimburse physicians. For the year ended September 30, 2014 and 2013, approximately $18,975,000 and $20,913,000, respectively, were included in net patient service revenue.

(13) Affiliated Organizations

The Foundation was established to solicit contributions from the general public on behalf of the Hospital for the funding of capital acquisitions and to support Hospital programs. As of September 30, 2014 and 2013, the Foundation held assets for the Hospital that were temporarily and permanently restricted by donors. The Hospital's interest in the net assets of the Foundation is included in assets limited as to use and amounted to approximately $7,597,000 and $6,548,000 as of September 30, 2014 and 2013, respectively.

The University of South Florida Board of Trustees (the University) has an affiliation agreement with the Center. The affiliation agreement establishes the Center as the primary teaching hospital for the University in order to provide healthcare education and training for students, residents, and other healthcare professionals. In accordance with the affiliation agreement, the University assigns physicians and residents to provide the customary services of the Center. For the years ended September 30, 2014 and 2013, the Center paid the University approximately $45,470,000 and $39,468,000, respectively, for these services, which also include the residents' salaries and the related malpractice coverage and medical director fees. These amounts are recorded within professional fees and other expenses in the accompanying consolidated statements of operations and changes in unrestricted net assets.

(14) Subsequent Events

The Center has evaluated events and transactions occurring subsequent to September 30, 2014 as of December 18, 2014, which is the date the consolidated financial statements were available to be issued, and has determined that no additional disclosures or adjustments are required.

Bio

Marty Makary, M.D.

Dr. Marty Makary is a Johns Hopkins surgeon and leading expert in patient safety. He was the creator of the Surgical Checklist later popularized in the book The Checklist Manifesto. He served on the World Health Organization (W.H.O.) Surgery Checklist workgroup and chaired the W.H.O. technical workgroup on measuring surgical quality worldwide.

Dr. Makary writes for The Wall Street Journal, Newsweek, and TIME Magazine. He is a medical commentator for FOX News and NBC's TODAY show, where he highlights the top research studies in JAMA and the New England Journal of Medicine. He is the author of the *New York Times* Bestselling book Unaccountable about doctor-led efforts to fix healthcare, and his newest book, Mama Maggie about a Nobel Prize nominee from the Middle East.

At Johns Hopkins, Dr. Makary is chief of Islet Transplantation Surgery and is a professor of Health Policy & Management at the Bloomberg School of Public Health. In 2006, Dr. Makary was named the Mark Ravitch endowed Chair of Gastrointestinal Surgery at Johns Hopkins, and in 2010 was named Director of Surgical Quality & Safety at Johns Hopkins. Last year, Dr. Makary was named to America's 20 Most Influential People in Health Care by Health Leaders Magazine.

Dr. Makary completed his education at Bucknell University, Thomas Jefferson University, and Harvard University and completed his general surgery residency at Georgetown University and further sub-specialty training in GI and cancer surgery at Johns Hopkins.

Morton Plant Hospital

1) Potentially Preventable Readmission Rate: 5.251677 % : Percentage of readmissions that are potentially preventable depending on the quality of care

   Potentially Preventable Readmission (PPRs) identify return hospitalizations that may have resulted from the process of care and treatment (readmission for a surgical wound infection) or lack of post admission follow-up (prescription not filled) rather than unrelated events that occur post admission.

2) Serious Complications Rate (Infection/Injury): 0.98 (index of 1 is average rate of serious complications across all hospitals)

   A complication that results when a patient is admitted to a hospital for one medical problem and develops a serious injury or infection that may result in death. These events can be prevented if hospitals follow best practices for treatment.

3) Hospital Consumer of Healthcare Providers and Systems (CAHPS) Five Star Patient Satisfaction Survey: 4 Stars

   The scale is 1-5 with 1 being the worst patient experience and 5 being the best. Enables consumers to more quickly assess patient experience of care information that is provided.

4) Patient Cost Per Procedure- The state does not currently collect data to determine actual payments between insurers and hospitals. The construction or establishment of multi-payer claims data base would help to bring transparency to this issue.

5) Emergency Room Wait Time for Diagnostic Evaluation: 26 Minutes
   The amount of time it takes to see a qualified medical professional and receive a diagnostic evaluation.

6) Physician/Nursing Quality- Quality is measured in part by patient satisfaction surveys and through the submission of adverse incident reports as defined in s. 395.0197, F. S. Hospitals are required to submit incident reports related to events that have resulted in death or serious injury within 15 calendar days. Additionally, each hospital is required to submit an annual Adverse Incident Report to the AHCA. These reports are not made available to the public pursuant to s. 119.07 (1), F.S., except in disciplinary proceedings.

Additional Information for Morton Plant (NFP):
CY 2013

Overall Profitability (Total Margin): $49,334,410 (11.7%)

Number of Admissions: 23,602

Case Mix: 1.65

Average Length of Stay: 4.7 days

Number of Emergency Department Visits: 62,965

Cost per Patient: $9,274

Number of FTE Physician Residents: 25.41

KPMG

MORTON PLANT MEASE HEALTH CARE, INC. AND AFFILIATES

Combined Financial Statements and Schedules

December 31, 2013

(With Independent Auditors' Report Thereon)

MORTON PLANT MEASE HEALTH CARE, INC.
AND AFFILIATES

Table of Contents

KPMG LLP
Suite 1700
100 North Tampa Street
Tampa, FL 33602-5145

Independent Auditors' Report

The Board of Directors
Morton Plant Mease Health Care, Inc. and Affiliates:

We have audited the accompanying combined financial statements of Morton Plant Mease Health Care, Inc. and Affiliates (the Organization), which comprise the combined balance sheet as of December 31, 2013, and the related combined statements of operations and changes in net assets, and cash flows for the year then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audit. We did not audit the financial statements of Morton Plant Mease Health Care Foundation, Inc., an indirect controlled subsidiary, which statements reflect total assets of approximately $109,398,000 as of December 31, 2013, and total revenues of approximately $1,272,000 for the year then ended. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Morton Plant Mease Health Care Foundation, Inc., is based solely on the report of the other auditors. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

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

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

KPMG

Opinion

In our opinion based on our audit and the report of other auditors, the combined financial statements referred to above present fairly, in all material respects, the combined financial position of Morton Plant Mease Health Care, Inc. and Affiliates as of December 31, 2013, and the changes in their net assets, and their cash flows for the year then ended, in accordance with U.S. generally accepted accounting principles.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the combined financial statements as a whole. The combining information included in Schedules 1 and 2 is presented for purposes of additional analysis and is not a required part of the combined financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the combined financial statements. The combining information has been subjected to the auditing procedures applied in the audit of the combined financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the combined financial statements or to the combined financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America by use and other auditors. In our opinion, based on our audit, the procedures performed as described above, and the report of other auditors, the combining information is fairly stated in all material respects in relation to the combined financial statements as a whole.

KPMG LLP

Tampa, Florida
March 20, 2014
Certified Public Accountants

MORTON PLANT MEASE HEALTH CARE, INC.
AND AFFILIATES

Combined Balance Sheet

December 31, 2013

(In thousands)

Assets

Current assets:		
Cash and cash equivalents	$	5,094
Accounts receivable, less allowance for uncollectible accounts of approximately $106,834		110,085
Inventories		16,184
Prepaid expenses and other current assets		9,372
Total current assets		140,735
Investments:		
Unrestricted Investments		16,838
Donor Restricted Investments		50,594
Total Investments		67,432
Assets limited as to use		1,267
Property and equipment, net		520,450
Remainder interest in irrevocable trusts		11,954
Beneficial interest in externally controlled trusts		14,993
Due from affiliates		879,498
Other assets		41,222
Total assets	$	1,677,551

Liabilities and Net Assets

Current liabilities:		
Accounts payable and accrued expenses	$	42,340
Employee compensation and benefits		31,217
Estimated third-party settlements		40,677
Current portion of long-term debt		614
Total current liabilities		114,848
Long-term debt and capital leases, less current portion		7,527
Other liabilities		9,130
Total liabilities		131,505
Net assets:		
Unrestricted		1,464,387
Temporarily restricted		55,039
Permanently restricted		26,620
Total net assets		1,546,046
Total liabilities and net assets	$	1,677,551

See accompanying notes to combined financial statements.

MORTON PLANT MEASE HEALTH CARE, INC.
AND AFFILIATES

Combined Statement of Operations and Changes in Net Assets

Year ended December 31, 2013

(In thousands)

Operating revenues:	
Patient service revenue (net of contractual adjustments and discounts)	$ 1,032,319
Provision for bad debts	(65,357)
Net patient service revenue less provision for bad debts	966,962
Other revenues	24,055
Total operating revenues	991,017
Operating expenses:	
Salaries and benefits	442,740
Supplies	179,447
Other expenses	231,590
Depreciation and amortization	57,776
Interest	11,628
Total operating expenses	923,181
Operating income	67,836
Nonoperating gains, net:	
Investment income, net	2,379
Other nonoperating gains, net	12,353
Total nonoperating gains, net	14,732
Excess of revenues and gains over expenses	82,568
Net unrealized gains on other-than-trading securities	1,315
Net asset transfers from Joint Operating Agreement participants	92,371
Contributions for purchase of property and equipment	443
Other	2,180
Increase in unrestricted net assets	178,877
Temporarily restricted net assets:	
Contributions	9,303
Net realized and unrealized gains on other-than-trading securities	5,159
Net assets released from restrictions for operations	(5,346)
Other	(2,221)
Increase in temporarily restricted net assets	6,895
Permanently restricted net assets:	
Contributions	25
Net realized and unrealized gains on other-than-trading securities	1,316
Other	199
Increase in permanently restricted net assets	1,540
Increase in net assets	187,312
Net assets at beginning of year	1,358,734
Net assets at end of year	$ 1,546,046

See accompanying notes to combined financial statements.

MORTON PLANT MEASE HEALTH CARE, INC.
AND AFFILIATES

Combined Statement of Cash Flows

Year ended December 31, 2013

(In thousands)

Cash flows from operating activities:		
Increase in net assets	$	187,312
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for bad debts		65,357
Depreciation and amortization		57,776
Net asset transfers from Joint Operating Agreement participants		(92,371)
Gain on sale of assets		(68)
Gain on disposition of business		(98)
Change in net unrealized gains on investments		(1,315)
Net realized gains on investments		(1,467)
Restricted contributions		(232)
Changes in:		
Accounts receivable, net		(63,911)
Inventories		(683)
Prepaid expenses and other current assets		1,400
Due from affiliates		(102,023)
Other assets		(1,435)
Accounts payable and accrued expenses		922
Employee compensation and benefits		596
Estimated third-party settlements		21,923
Other liabilities		792
Net cash provided by operating activities		72,475
Cash flows from investing activities:		
Purchases of property and equipment		(63,313)
Proceeds from the sale of property and equipment		261
Change in irrevocable and externally controlled trusts		(1,802)
Purchases of investments		(51,019)
Proceeds from the sale of investments		43,854
Net cash used in investing activities		(72,019)
Cash flows from financing activities:		
Repayments of long-term debt		(572)
Restricted contributions		232
Net cash used in financing activities		(340)
Increase in cash and cash equivalents		116
Cash and cash equivalents at beginning of year		4,978
Cash and cash equivalents at end of year	$	5,094
Supplemental disclosure of cash flow information:		
Transfer of equipment to affiliated organization	$	1,915
Acquisition of property and equipment through accrued expenses	$	8,655

See accompanying notes to combined financial statements.

(1) Organization

Morton Plant Mease Health Care, Inc. and Affiliates (the Organization) was organized pursuant to a partnership agreement between Morton Plant Hospital Association, Inc. (Morton Plant) and Trustees of Mease Hospital, Inc. (Mease Health Care), effective October 1, 1994. The Organization was organized to prevent unnecessary duplication of services, to provide greater access to healthcare services, and to enhance the quality of care provided.

Effective July 1, 1997, the Organization executed a joint operating agreement (JOA) along with Catholic Health East, South Florida Baptist Hospital, Inc. (collectively, the Members), and BayCare Health System, Inc. (BayCare), to develop a regional healthcare network providing for a collaborative effort in the areas of community healthcare delivery, enhanced access to healthcare services for the poor, and the sharing of other common goals. Effective June 1, 2005, the Organization became the sole member and parent of Morton Plant and Mease Health Care. Since that date, the parent and subsidiaries have been jointly included in the JOA. The JOA provides for the Members to maintain ownership of their assets while agreeing to operate as one organization with common governance and management and is effective for a period of 50 years.

Terms of the JOA provide that residual-free cash flow, as defined, as well as funding for capital expenditures, is allocated among the Members based on predetermined percentages. The amount allocated to the Organization from the other participants under the JOA totaled approximately $92,371,000 for the year ended December 31, 2013. This amount is included as a component of due from affiliates in the combined balance sheet and net asset transfers from JOA participants in the combined statement of operations and changes in net assets.

The partnership agreement established that members of the board of directors of the Organization will be appointed by Morton Plant and Mease Health Care separately. The board of trustees of Morton Plant and the board of trustees of Mease Health Care collectively comprise the board of directors of the Organization.

The combined financial statements include the accounts of the following not-for-profit organizations, which are exempt from federal and state income taxes:

Morton Plant Mease Health Care, Inc. (MPMHC) (formerly, Morton Plant Health System, Inc.), which owns and operates certain eligible partnership services for the benefit of the community;

Morton Plant Hospital Association, Inc., which operates two acute care hospitals, rehabilitation facilities, and outpatient centers;

Morton Plant Mease Primary Care, Inc., which operates offices in Pinellas and Pasco counties;

Trustees of Mease Hospital, Inc., which operates two acute care hospitals and medical office buildings; and

Morton Plant Mease Health Services, Inc., which operates three outpatient imaging centers, an ambulatory surgery center, two wellness centers, and three medical office buildings.

(Continued)

Morton Plant Mease Health Care Foundation, Inc. (the Foundation), which engages in fund-raising activities for the benefit of the Organization.

In addition, these combined financial statements include the accounts of Morton Plant Mease Health Ventures, Inc., a for-profit company wholly owned by MPMHC and created to invest in certain health ventures, and its subsidiary MFP, Inc., which provides billing and collection services (collectively, Morton Plant Mease Health Ventures).

All significant intercompany transactions among these entities have been eliminated from the combined financial statements.

(2) Summary of Significant Accounting Policies

(a) Use of Estimates

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

(b) Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid instruments with a maturity of three months or less when purchased.

(c) Contributions Receivable

Unconditional promises to give the Foundation cash or other assets in the future are recorded as contribution revenue. If management expects the cash from the contribution receivable to be received more than one year in the future, the contribution revenue and receivable are discounted to present value. The discount rate was 5% for all pledges received through December 31, 2010 and 3% for all pledges received through December 31, 2011. Effective January 1, 2012, the discount rate was 2.5%. Such receivables of approximately $10,327,000 are included in other assets in the combined balance sheet.

(d) Assets Limited as to Use, Investments, and Investment Income

Assets limited as to use include resident funds and the cash surrender value recoverable from the proceeds of life insurance policies held by the Organization.

The Organization has designated substantially all of its investments as other-than-trading. Investments in debt and equity securities with readily determinable fair values are measured at fair value using quoted market prices. Investment income (including realized gains and losses, interest, and dividends) is included in excess of revenues and gains over expenses unless such earnings are subject to donor-imposed restrictions. Investment income restricted by donor stipulations is reported as an increase in temporarily restricted net assets. Unrealized gains and losses on investments are reported as a change in unrestricted net assets.

(Continued)

(e) Inventories

Inventories consist principally of medical and surgical supplies and pharmaceuticals and are valued at lower of cost (first-in, first-out method) or market.

(f) Property and Equipment

Property and equipment are recorded at historical cost at the date of acquisition or fair value at the date of donation.

Depreciation and amortization expense is calculated using the straight-line method over the estimated useful lives of the property and equipment or the lease term, whichever is less. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase capacities or extend useful lives are capitalized. Interest cost on borrowed funds during the construction period is capitalized as a component of the cost of the assets.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support, and are excluded from revenues and gains over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service. Property and equipment consist of the following as of December 31, 2013 (in thousands):

Land	$	46,077
Land improvements		24,414
Buildings and improvements		618,472
Equipment		410,179
		1,099,142
Less accumulated depreciation and amortization		642,055
		457,087
Construction in progress		63,363
Property and equipment, net	$	520,450

Interest costs of approximately $988,000 were capitalized during the year ended December 31, 2013. Included in buildings and equipment are assets leased under capital leases with a net book value of approximately $5,393,000, net of accumulated amortization of approximately $6,313,000 as of December 31, 2013.

(Continued)

The Organization has construction commitments of approximately $71,788,000 relating to various construction projects as of December 31, 2013. The Organization expects to fund substantially all of those commitments through operations and the investment program managed by BayCare.

The Organization reviews whether events and circumstances have occurred to indicate if the remaining useful life of long-lived assets may warrant revision or that the remaining balance of an asset may not be recoverable. If such an event occurs, an assessment of possible impairment is based on whether the carrying amount of the assets exceeds the expected total undiscounted cash flows expected to result from the use of the assets and their eventual disposition. If the undiscounted cash flows are less than the net book value of the assets, an impairment loss based on the fair value of the assets is recognized. No impairments were recorded in 2013.

(g) Remainder Interest in Irrevocable Trusts

The fair value of irrevocable trust agreements in which the Foundation has a remainder interest is recorded in the period the gift is received, unless management expects the cash from these contributions to be received more than one year in the future. Such irrevocable trust agreements amounting to approximately $11,954,000 at December 31, 2013 are discounted using the Internal Revenue Service discount rate in effect at the date of the gift.

(h) Beneficial Interest in Externally Controlled Trusts

The Foundation receives income from certain trusts, which are neither in its possession nor under its control. These external endowment assets are invested and managed by outside trustees in accordance with trust instruments established by the respective donors and, therefore, are not subject to the Foundation's investment and spending policies. The Foundation was the beneficiary of such trusts having an aggregate fair value, measured at the present value of the estimated future distributions expected to be received over the expected term of the agreements, of approximately $14,993,000 at December 31, 2013.

(i) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Organization are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the combined statement of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying combined financial statements.

(j) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Organization has been limited by donors to a specific time period or purpose. Temporarily restricted net assets are maintained primarily for

(Continued)

the purposes of patient care related services, capital improvements, and research and education. During the year ended December 31, 2013, approximately $5,346,000 of temporarily restricted net assets were released for payment of operating expenses. Permanently restricted net assets have been restricted by donors to be maintained by the Organization in perpetuity.

(k) Gift Annuity Contracts

On November 19, 1987, the Foundation received a certificate of authority from the State of Florida Insurance Commissioner to directly market and manage gift annuity contracts.

For consideration received, the Foundation pays a fixed annuity amount to the donors for their lifetimes. The annuity amount is dependent upon the amount of the gift and the actuarially determined remaining life of the donors.

The net present values of obligations under gift annuity contracts of approximately $7,178,000 are included in other liabilities in the combined balance sheet at December 31, 2013, based upon the donor life expectancy and discount rates prescribed by the Internal Revenue Service's actuarial model at the date of the gift and are held consistent subsequent to that date. The excess of the annuity gift received over the recorded liability is recorded as revenue in the year of receipt. The board of directors can designate all or part of this excess as a reserve to ensure fulfillment of the obligations related to the gift annuity contracts.

(l) Net Patient Service Revenue

Net patient service revenue is reported at estimated net realizable amounts from patients, third-party payors, and others for services rendered, and includes estimated retroactive revenue adjustments due to future audits, reviews, and investigations. The Organization has agreements with third-party payors that provide for payments to the Organization at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. The Organization provides discounts to uninsured patients who do not qualify for Medicaid, charity care, or county funding.

Revenue from the Medicare and Medicaid programs accounted for approximately 43% and 7% and of the Organization's net patient service revenue for the year ended December 31, 2013. The composition of patient service revenue (net of contractual adjustments and discounts) but before the provision for bad debts recognized from these major payor sources is as follows (in thousands):

	Third-party payors	Self-pay	Total all payors
Patient service revenue (net of contractual adjustments and discounts)	$ 992,679	39,640	1,032,319

The Organization analyzes its past collection history and identifies trends by each of its major payor sources of patient service revenue to estimate the appropriate allowance for doubtful accounts and

(Continued)

provision for bad debts. Management regularly reviews data about the major payor sources of patient service revenue in evaluating the adequacy of the allowance for doubtful accounts.

The Organization analyzes contractual amounts due from patients who have third-party coverage and provides an allowance for doubtful accounts and a provision for bad debts. For self-pay patients, which includes those patients without insurance coverage and patients with deductibles and copayment balances for which third-party coverage exists for a portion of the bill, the Organization records a significant provision for bad debts for patients that are unwilling to pay for the portion of the bill representing their financial responsibility. Account balances are charged off against the allowance for doubtful accounts after all means of collection have been exhausted. The Organization follows established guidelines for placing certain past-due patient balances with a collection agency.

The Organization's allowance for uncollectible accounts for self-pay patients was 41% of self-pay accounts receivable as of December 31, 2013. The Organization has not experienced significant changes in write-off trends and has not changed its uninsured discount or charity care policies for the year ended December 31, 2013.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates associated with these programs will change by a material amount in the near term. As a result, provisions for third-party payor settlements and adjustments are estimated in the period the related services are provided and adjusted in future periods as additional information becomes available and as final settlements are determined or as years are no longer subject to audits, reviews and investigations. Net patient service revenue increased approximately $6,025,000 during the year ended December 31, 2013 due to final settlements on open cost report filings, specific settlement of certain appeal issues, and changes in recorded estimates for retroactive adjustments.

The Organization grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. Net patient accounts receivable included approximately $35,452,000, or 32%, due from the Medicare program and approximately $8,520,000, or 8%, due from the Medicaid program as of December 31, 2013. The credit risk for other concentrations of receivables is limited due to the large number of insurance companies and other payors that provide payments for services.

(m) Community Commitment

The Organization exists to meet the healthcare needs of the community. Patients who are uninsured or underinsured and cannot pay for hospital services are eligible for either traditional or hardship charity consideration.

The Agency for Health Care Administration (AHCA) defines traditional charity care eligibility at 200% of the federal poverty guidelines, unless the amount due from the patient exceeds 25% of annual family income limited to four times the poverty level. In an effort to meet its mission, the Organization affords its patients a hardship charity, which is defined as 250% of the federal poverty guidelines. Accordingly, services are being provided to the community at no charge or for which

(Continued)

costs exceed the payments received. Because payment is not pursued from patients meeting these guidelines, such amounts are not reported as net patient service revenue.

Payments received from Medicaid and other means-tested (based on patients' income level) programs are significantly less than established patient charges and are less than management's estimate of the costs of providing those services. These payments reduce the community commitment costs. An assessment of 1.0% to 1.5% of certain operating revenue earned and recorded is paid by the Organization to help fund the Florida Medicaid and indigent care program. The assessment has been included in the Medicaid and other means-tested program amounts below. Reimbursement received under the uncompensated and indigent care programs are included as subsidized costs.

Unbilled community services represent management's estimate of the cost of providing various programs to the community at no or little charge. These programs include health screenings, educational programs, sponsorships, and research.

The table below is a summary of the Organization's community commitment as measured by unreimbursed costs (estimated by the Organization's cost accounting system) as of December 31, 2013 (in thousands):

	Charity care	Medicaid and other means-tested programs	Unbilled community services	Total
Community commitment	$ 49,070	41,654	4,086	94,810
Subsidized costs	—	(1,041)	—	(1,041)
Net community commitment	$ 49,070	40,613	4,086	93,769

(n) Electronic Health Record Incentive Payments

The American Recovery and Reinvestment Act of 2009 provides for incentive payments under the Medicare and Medicaid programs for certain hospitals and professionals that adopt and use electronic health records (EHR) in a meaningful way. Meaningful use is demonstrated by meeting established criteria that focus on capturing and using electronic health information to improve health care quality, efficiency, and patient safety.

The Organization records incentive payments under the grant accounting model. Revenue is recorded at the end of the EHR reporting period when it is reasonably assured that it has met the meaningful use requirements. The Organization recognized approximately $606,000 of incentive payments in other revenues for the year ended December 31, 2013. Incentive payment revenue is subject to change as the result of audits of compliance with meaningful use criteria and Medicare cost reports, with changes recorded in the period they occur.

(Continued)

(o) Excess of Revenues and Gains over Expenses and Changes in Unrestricted Net Assets

Activities deemed by the Organization to be a provision of healthcare services are reported as operating revenues and expenses. Other activities that are peripheral to providing healthcare services are reported as nonoperating gains and losses. Consistent with industry practice, other changes in unrestricted net assets are excluded from excess of revenues and gains over expenses.

(p) Income Taxes

The majority of the affiliates within the Organization are not-for-profit organizations described in Section 501(c)(3) of the Internal Revenue Code, and are exempt from federal income taxes on related income pursuant to Section 501(a) of the Internal Revenue Code, and are also exempt from state taxes. Management believes that the unrelated business income generated by the Organization and its exempt affiliates is not material to the combined financial statements.

(q) Fair Value Measurements

The Organization applies the provisions of Financial Accounting Standards Board Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, to fair value measurements of financial and nonfinancial assets and liabilities that are recognized or disclosed at fair value in the combined financial statements on a recurring and nonrecurring basis.

Fair value guidance defines fair value as the exit price that would be received to sell an asset or paid to transfer a liability under the current market conditions, in the principal or most advantageous market to the asset or liability, in an orderly transaction between market participants on the measurement date. It requires assets and liabilities to be grouped into three categories based on certain criteria as noted below:

- Level 1: Fair value is determined by using quoted prices for identical assets or liabilities in active markets.

  The Organization's Level 1 assets include trading and other-than-trading investments in U.S. and international equities, mutual funds, fixed income, and exchange traded products and are valued at the quoted market prices.

- Level 2: Fair value is determined by using quoted prices for identical assets or liabilities in inactive markets, quoted prices for similar assets or liabilities in active markets, observable inputs other than quoted prices, and market corroborated inputs.

  The Organization's Level 2 assets include trading and other-than-trading investments valued using the estimated net asset value per share of the investments and commingled mutual funds, International Securities, U.S. Treasuries, other government securities, corporate debt securities, global securities, derivatives, exchange-traded funds, and asset-backed securities with fair values modeled by external pricing vendors.

- Level 3: Fair value is determined by using inputs based on various assumptions that are not directly observable.

(Continued)

The Organization's Level 3 assets include property and estates and externally controlled trusts and endowments relating to the remainder interest in irrevocable trusts and the beneficial interest in externally controlled trusts.

(3) Assets Limited as to Use and Investments

The table below summarizes the fair values of the Organization's assets limited as to use and the Foundation's investments as of December 31, 2013 (in thousands). See note 2(q) for a discussion of valuation methodologies.

	December 31, 2013	Fair value measurements at reporting date	
		Level 1	Level 2
Asset class:			
Cash	$ 5,664	5,664	—
Equity securities:			
U.S.	27,971	27,971	–
International	14,670	14,352	318
Fixed income securities			
Core	15,568	7,556	8,012
Global	883	—	883
Other types of investments:			
Real assets	3,943	3,943	–
	$ 68,699	59,486	9,213

There were no reportable transfers between levels during the year.

Investment income and gains for the year ended December 31, 2013 comprise the following (in thousands):

Investment income:	
Interest and dividends	$ 912
Net realized gains on investments	1,467
	2,379
Other changes in net assets:	
Changes in net unrealized gains on other-than-trading securities	1,315
	1,315
Total investment return	$ 3,694

Investment income is recorded net of investment expense, which was approximately $393,000 for the year ended December 31, 2013.

(Continued)

(4) Long-Term Debt and Capital Leases

The Organization is obligated under long-term debt as of December 31, 2013 (in thousands):

Mease Countryside medical office building capital lease, interest at 8.73%, payable through 2022	$	4,283
Orthopedic Pavilion office building capital lease, interest at 9.13%, payable through 2024		3,552
Other		306
		8,141
Less current portion of long-term debt		(614)
Long-term debt, less current portion	$	7,527

Aggregate maturities of long-term debt and capital lease obligations as of December 31, 2013 (in thousands) are as follows:

2014	$	614
2015		656
2016		710
2017		967
2018		833
Thereafter		4,361
	$	8,141

The carrying amount of the Institute's long-term debt approximates its fair value at December 31, 2013.

(5) Goodwill

Goodwill of approximately $14,023,000, included in other assets, results from the excess of the amount paid over the fair value of tangible assets and liabilities of acquired healthcare businesses. The Organization reviews goodwill for impairment at least annually or whenever events or circumstances indicate that the carrying value may not be recoverable in accordance with the provisions of FASB ASC Topic 350, *Accounting for Intangibles – Goodwill and Other.*

The annual impairment test was completed and it was determined that no impairment existed at December 31, 2013. No recent events or circumstances have occurred to indicate that impairment may exist.

(6) Commitments and Contingencies

(a) Professional Liability

Effective October 1, 1998, the Organization became insured through an insurance agreement with BayCare's wholly owned insurance captive for all incidents reported after September 30, 1998. The

(Continued)

insurance provided by the captive is on a claims-made basis. The estimated liability for known claims and claims incurred but not reported is recorded in BayCare's combined financial statements.

(b) Litigation

The Organization is currently the subject of litigation other than professional liability litigation, as well as inquiries by federal agencies. The litigation generally involves matters of healthcare and employment law, as well as certain matters, which arise in the ordinary course of business. The inquiries generally involve the application of complex healthcare regulations. The Organization is fully cooperating with the federal agencies in connection with their inquires. Based on current information, management believes at this time that the results of the litigation are not likely to have a material adverse effect on the combined financial position and results of the Organization.

On November 19, 2012, the Organization entered into a settlement agreement with the federal government to resolve allegations that the organization along with two affiliated Catholic Health East BayCare participants violated the False Claims Act related to the statusing of certain Medicare patients who were billed as inpatients from 2006 to 2008 primarily with respect to cardiac procedures. The Organization also entered into a 5-year Corporate Integrity Agreement as part of the settlement.

(c) Operating Leases

The Organization leases various equipment and facilities under operating leases expiring at various dates. Rental expense for operating leases totaled approximately $8,215,000 for the year ended December 31, 2013.

Future minimum payments required under noncancelable operating leases for each of the five years subsequent to December 31, 2013 and thereafter (in thousands) are as follows:

2014	$	4,406
2015		3,826
2016		3,290
2017		2,354
2018		1,641
Thereafter		4,151
Total	$	19,668

(7) Retirement Plan

The Organization participates in the BayCare Health System Retirement Plan (the Plan), a defined contribution plan that covers substantially all employees who meet certain service requirements. For these employees, the Plan provides that the Organization will contribute 2% of wages and also match 50% of the employee's contributions up to 6% of the contributing employee's wages. Total contribution expense attributable to the Plan for the year ended December 31, 2013 was approximately $11,871,000.

(Continued)

(8) Related-Party Transactions

The Organization has entered into agreements with BayCare, whereby the Organization is assessed for certain management fees, professional liability, property, and workers' compensation insurance, interest expense, depreciation, employee health benefits, marketing, planning, information services, finance and treasury services, and other services. The Organization was assessed approximately $132,526,000 by BayCare during the year ended December 31, 2013.

MPMHC, Trustees of Mease Hospital, Inc., and Morton Plant Hospital Association, Inc. are members of the BayCare Obligated Group, which consists of certain members of BayCare (collectively, the Obligated Entities). All of the outstanding bonds of the Obligated Entities are subject to a Master Trust Indenture and constitute BayCare Obligated Group indebtedness. The outstanding amount of BayCare Obligated Group bond proceeds received to date by the Organization are included in due from affiliates in the accompanying combined balance sheet. The covenants in connection with the long-term debt agreements described above provide for the maintenance of certain levels of debt coverage and working capital, certain restrictions on additional indebtedness, and certain types and amounts of insurance protection. As a member of the BayCare Obligated Group, the Obligated Entities are liable for the BayCare Obligated Group bonds and other debt of the BayCare Obligated Group of approximately $974,720,000 as of December 31, 2013.

Since bond payments are made at the BayCare level, Obligated Group entities are allocated an interest expense charge from BayCare. As these payments are not made at the Obligated Group entity level, the combined statement of cash flows does not contain recognition and/or disclosure related to debt and interest payments on the outstanding bonds. Due from affiliates is a noncurrent asset since management of the Organization does not expect the amount to be paid during 2014. The balance consists of the net cash flows of the Organization transferred to BayCare, less amounts paid by BayCare and Affiliates on behalf of the Organization.

(9) Subsequent Events

The Organization has evaluated events and transactions occurring subsequent to December 31, 2013 as of March 20, 2014, which is the date the combined financial statements were available to be issued. Management believes that no material events have occurred since December 31, 2013 that requires recognition or disclosure.

COMBINING INFORMATION

Schedule 1

MORTON PLANT MEASE HEALTH CARE, INC.
AND AFFILIATES

Combining Schedule – Balance Sheet Information

December 31, 2013

(In thousands)

	Morton Plant Mease Health Care	Morton Plant Hospital	Morton Plant North Bay Hospital	Morton Plant Rehabilitation Center	Morton Plant Physician Services	Morton Plant Health Services	Morton Plant Mease Health Ventures	Mease Hospitals	Mease Medical Offices	Subtotal	Morton Plant Mease HealthCare Foundation	Eliminations	Combined
Assets													
Current assets:													
Cash and cash equivalents	$ (40)	797	1	14	29	189	3,471	320	—	4,781	313	—	5,094
Accounts receivable, net	1,349	51,674	10,549	2,230	1,820	3,231	—	39,232	—	110,085	—	—	110,085
Inventories	69	8,260	1,792	—	13	216	—	5,834	—	16,184	—	—	16,184
Prepaid expenses and other current assets	579	2,973	416	15	1,761	87	652	2,695	194	9,372	—	—	9,372
Total current assets	1,957	63,704	12,758	2,259	3,623	3,723	4,123	48,081	194	140,422	313	—	140,735
Investments:													
Unrestricted Investments	—	—	—	—	—	—	—	—	—	—	16,838	—	16,838
Donor Restricted Investments	—	—	—	—	—	—	—	—	—	—	50,594	—	50,594
Total Investments	—	—	—	—	—	—	—	—	—	—	67,432	—	67,432
Assets limited as to use	—	—	—	1	1,266	—	—	—	—	1,267	—	—	1,267
Property and equipment, net	5,355	227,962	82,652	3,607	2,104	27,134	131	164,614	6,445	520,004	446	—	520,450
Remainder interest in irrevocable trusts	—	—	—	—	—	—	—	—	—	—	11,954	—	11,954
Beneficial interest in externally controlled trusts	—	—	—	—	—	—	—	—	—	—	14,993	—	14,993
Beneficial interest in net assets of foundation	100,632	—	—	—	—	—	—	—	—	100,632	—	(100,632)	—
Due from affiliates	160,814	482,358	(79,621)	(1,305)	—	7,513	804	297,988	10,947	879,498	—	—	879,498
Other assets	18	20,099	17	1	129	949	1	5,748	—	26,962	14,260	—	41,222
Total assets	$ 268,776	794,123	15,806	4,563	7,122	39,319	5,059	516,431	17,586	1,668,785	109,398	(100,632)	1,677,551
Liabilities and Net Assets													
Current liabilities:													
Accounts payable and accrued expenses	$ 4,337	17,914	3,380	523	2,027	389	1,955	11,443	11	41,979	361	—	42,340
Employee compensation and benefits	7,290	9,171	2,851	705	2,830	711	61	7,598	—	31,217	—	—	31,217
Estimated third-party settlements	—	29,018	993	224	—	—	—	10,442	—	40,677	—	—	40,677
Current portion of long-term debt	—	170	10	—	—	35	28	371	—	614	—	—	614
Total current liabilities	11,627	56,273	7,234	1,452	4,857	1,135	2,044	29,854	11	114,487	361	—	114,848
Long-term debt and capital leases, less current portion	—	3,382	227	—	—	6	—	3,912	—	7,527	—	—	7,527
Other liabilities	13	93	31	—	55	405	—	128	—	725	8,405	—	9,130
Total liabilities	11,640	59,748	7,492	1,452	4,912	1,546	2,044	33,894	11	122,739	8,766	—	131,505
Net assets:													
Unrestricted	175,852	734,001	8,314	3,110	2,210	37,773	3,015	482,537	17,575	1,464,387	19,647	(19,647)	1,464,387
Temporarily restricted	54,664	374	—	1	—	—	—	—	—	55,039	54,365	(54,365)	55,039
Permanently restricted	26,620	—	—	—	—	—	—	—	—	26,620	26,620	(26,620)	26,620
Total net assets	257,136	734,375	8,314	3,111	2,210	37,773	3,015	482,537	17,575	1,546,046	100,632	(100,632)	1,546,046
Total liabilities and net assets	$ 268,776	794,123	15,806	4,563	7,122	39,319	5,059	516,431	17,586	1,668,785	109,398	(100,632)	1,677,551

See accompanying independent auditors' report.

Schedule 2

MORTON PLANT MEASE HEALTH CARE, INC.
AND AFFILIATES

Combining Schedule – Statement of Operations and Changes in Net Assets Information

Year ended December 31, 2013

(In thousands)

	Morton Plant Mease Health Care	Morton Plant Hospital	Morton Plant North Bay Hospital	Morton Plant Rehabilitation Center	Morton Plant Physician Services	Morton Plant Health Services	Morton Plant Mease Health Ventures	Mease Hospitals	Mease Medical Offices	Eliminations	Subtotal	Morton Plant Mease HealthCare Foundation	Eliminations	Combined
Operating revenues:														
Patient service revenue (net of contractual adjustments and discounts)	$ 18,178	462,111	110,975	16,784	42,224	38,003	—	344,044	—	—	1,032,319	—	—	1,032,319
Provision for bad debts	(1,037)	(29,116)	(9,361)	(302)	(867)	(1,651)	—	(22,341)	—	—	(64,675)	(682)	—	(65,357)
Net patient service revenue less provision for bad debts	17,141	432,995	101,614	16,482	41,357	36,352	—	321,703	—	—	967,644	(682)	—	966,962
Other revenues	1,811	3,224	799	12	2,746	5,195	4,845	3,891	1,152	(866)	22,809	1,246	—	24,055
Total operating revenues	18,952	436,219	102,413	16,494	44,103	41,547	4,845	325,594	1,152	(866)	990,453	564	—	991,017
Operating expenses:														
Salaries and benefits	50,015	144,334	49,264	9,556	50,277	11,496	2,260	123,729	—	—	440,921	1,819	—	442,740
Supplies	1,476	98,202	14,443	2,406	2,869	3,759	93	55,560	27	—	178,835	612	—	179,447
Other expenses	(24,742)	115,181	29,735	4,752	1,397	22,410	1,828	75,639	401	(866)	225,735	5,855	—	231,590
Depreciation and amortization	2,336	24,687	6,729	330	1,180	3,825	69	18,177	423	—	57,756	20	—	57,776
Interest	—	4,776	1,472	—		33	2	5,345	—	—	11,628	—	—	11,628
Total operating expenses	29,085	387,170	101,643	17,044	55,723	41,523	4,252	278,450	851	(866)	914,875	8,306	—	923,181
Operating income (loss)	(10,133)	49,049	770	(550)	(11,620)	24	593	47,144	301	—	75,578	(7,742)	—	67,836
Nonoperating gains, net:														
Investment income, net	(7)	115	—	1	3	29	—	—	16	—	157	2,222	—	2,379
Other nonoperating gains (losses), net	8,088	171	(3)	—	105	1,735	—	74	—	—	10,170	5,173	(2,990)	12,353
Total nonoperating gains (losses), net	8,081	286	(3)	1	108	1,764	—	74	16	—	10,327	7,395	(2,990)	14,732
Excess (deficiency) of revenues and gains over expenses	(2,052)	49,335	767	(549)	(11,512)	1,788	593	47,218	317	—	85,905	(347)	(2,990)	82,568
Net unrealized gains on other-than-trading securities	—	—	—	—	—	—	—	—	—	—	—	1,315	—	1,315
Net asset transfers from joint operating agreement participants	92,371	—	—	—	—	—	—	—	—	—	92,371	—	—	92,371
Contributions for purchases of property and equipment	443	—	—	—	—	—	—	—	—	—	443	—	—	443
Transfer to affiliates	(9,329)	—	—	—	9,329	—	—	—	—	—	—	—	—	—
Other	—	—	—	—	—	158	—	—	—	—	158	2,022	—	2,180
Increase (decrease) in unrestricted net assets	81,433	49,335	767	(549)	(2,183)	1,946	593	47,218	317	—	178,877	2,990	(2,990)	178,877
Temporarily restricted net assets:														
Contributions	—	232	—	—	—	—	—	—	—	—	232	9,071	—	9,303
Net realized and unrealized gains on other-than-trading securities	—	—	—	—	—	—	—	—	—	—	—	5,159	—	5,159
Change in beneficial interest in net assets of foundation	6,862	—	—	—	—	—	—	—	—	—	6,862	—	(6,862)	—
Net assets released from restrictions for operations	(18)	(181)	—	—	—	—	—	—	—	—	(199)	(5,147)	—	(5,346)
Other	—	—	—	—	—	—	—	—	—	—	—	(2,221)	—	(2,221)
Increase in temporarily restricted net assets	6,844	51	—	—	—	—	—	—	—	—	6,895	6,862	(6,862)	6,895
Permanently restricted net assets:														
Contributions	—	—	—	—	—	—	—	—	—	—	—	25	—	25
Net realized and unrealized gains on other-than-trading securities	—	—	—	—	—	—	—	—	—	—	—	1,316	—	1,316
Change in beneficial interest in net assets of foundation	1,541	—	—	—	—	—	—	—	—	—	1,541	—	(1,541)	—
Other	(1)	—	—	—	—	—	—	—	—	—	(1)	200	—	199
Increase in permanently restricted net assets	1,540	—	—	—	—	—	—	—	—	—	1,540	1,541	(1,541)	1,540
Increase (decrease) in net assets	89,817	49,386	767	(549)	(2,183)	1,946	593	47,218	317	—	187,312	11,393	(11,393)	187,312
Net assets, beginning of year	167,319	684,989	7,547	3,660	4,393	35,827	2,422	435,319	17,258	—	1,358,734	89,239	(89,239)	1,358,734
Net assets, end of year	$ 257,136	734,375	8,314	3,111	2,210	37,773	3,015	482,537	17,575	—	1,546,046	100,632	(100,632)	1,546,046

See accompanying independent auditors' report.

Additional Information Requested by Members

By Ge Bai and Gerard F. Anderson

Extreme Markup: The Fifty US Hospitals With The Highest Charge-To-Cost Ratios

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NO. 6 (2015): –

ABSTRACT Using Medicare cost reports, we examined the fifty US hospitals with the highest charge-to-cost ratios in 2012. These hospitals have markups (ratios of charges over Medicare-allowable costs) approximately ten times their Medicare-allowable costs compared to a national average of 3.4 and a mode of 2.4. Analysis of the fifty hospitals showed that forty-nine are for profit (98 percent), forty-six are owned by for-profit hospital systems (92 percent), and twenty (40 percent) operate in Florida. One for-profit hospital system owns half of these fifty hospitals. While most public and private health insurers do not use hospital charges to set their payment rates, uninsured patients are commonly asked to pay the full charges, and out-of-network patients and casualty and workers' compensation insurers are often expected to pay a large portion of the full charges. Because it is difficult for patients to compare prices, market forces fail to constrain hospital charges. Federal and state governments may want to consider limitations on the charge-to-cost ratio, some form of all-payer rate setting, or mandated price disclosure to regulate hospital markups.

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In the United States, hospitals use the chargemaster, a list of procedure codes with corresponding prices for thousands of billable items, to record services provided, determine the charges for each service, and generate hospital bills.[1,2] Chargemaster rates are established by individual hospitals and are not subject to any limit in most states. The rates are often several times the Medicare-allowable cost of providing care.[1]

Except in a few situations, hospital markups (ratios of charges over Medicare-allowable costs) do not have an effect on the amounts publicly insured patients pay because Medicare and Medicaid determine their own rules for paying hospitals.[1,3] Other patients, however, can be negatively affected by high hospital markups.

Uninsured patients, who lack bargaining power, are commonly subject to the full hospital charges, and their medical bills may be sent to bill collectors if they do not pay the high markups.[1–3] An estimated thirty million people will remain uninsured even after the full implementation of the Affordable Care Act (ACA).[4] Patients with health insurance who receive care at out-of-network hospitals generally do not benefit from their private insurers' negotiated rates with in-network hospitals and, therefore, may be expected to pay a high proportion of the full hospital charges. Casualty and workers' compensation insurers are usually obliged by law to allow the insured person to go to any hospital, which means that they cannot use selective contracting to get lower rates and thus often pay a high percentage of hospital charges. Since most American workers have casualty and workers' compensation insurance, exposure to these high markups adds to their insurance premiums.

Privately insured in-network patients may also pay greater premiums as a result of high hospital

markups. Hospitals with substantial market power can use the high markups as leverage with private insurers in price negotiations.[5] High markups and the possibility for high revenues from out-of-network patients make the option of joining a network less attractive to these hospitals, so they are less willing to negotiate with private insurers. At the same time, insurers are motivated to include hospitals in their networks to reduce the likelihood of having subscribers pay high out-of-network prices. Consequently, high markups may add to private insurance premiums and play a role in the rise of overall health care spending.[5]

Collectively, this system has the effect of charging the highest prices to the most vulnerable patients and those with the least market power.[1–3,6,7] While it is not uncommon for those with the least market power to pay the highest prices in many industries, in the case of hospitals, the very large differential in the markups charged to various patient groups and the pivotal role played by hospitals in caring for critically ill patients are worthy of policy makers' attention.

Controversy over very high hospital charges has triggered media attention, numerous lawsuits, activism on the part of consumer groups, and efforts to limit hospital charges.[8–11] However, no federal or state law, other than in Maryland and West Virginia, regulates hospital markups.[12] The ACA requires nonprofit hospitals to provide discounts to eligible uninsured patients. However, the same provision lets individual nonprofit hospitals determine their own eligibility standards, does not address the levels of the markup faced by out-of-network patients and casualty and workers' compensation insurers, and does not apply to for-profit hospitals.[13]

In this study we examined the fifty hospitals in the nation with the highest markups in 2012. We first examined the descriptive characteristics of all hospitals in our sample and then focused on the fifty hospitals with the highest charge-to-cost ratios. We describe their characteristics and geographic distribution and then discuss the causes and negative consequences of high hospital markups. We conclude by making policy recommendations.

Study Data And Methods

DATA We used the 2012 Medicare cost reports from the Centers for Medicare and Medicaid Services (CMS). The cost reports contain financial information for all Medicare-certified hospitals in the nation for their fiscal year beginning sometime between May 1, 2012, and April 30, 2013. We deleted forty-nine hospitals that had data anomalies in their charge-to-cost ratios. These hospitals had charge-to-cost ratios less than 0.2, and forty-four of them did not report any net revenue information on the cost report. Our final sample contained 4,483 hospitals.

CHARGE-TO-COST RATIO We used the overall hospital charge-to-cost ratio to measure the markup of chargemaster rates over Medicare-allowable costs. The charge-to-cost ratio is calculated as a hospital's total gross charges divided by its total Medicare-allowable cost.[1] We obtained the gross charge data from line 202 in column 5 of Form CSM-2552-10, Worksheet C, part I, "Calculation of Ratio of Costs to Charges," submitted by the hospitals. The Medicare-allowable cost refers to the cost determined by the CMS to be associated with care for all patients, not just Medicare patients.[1] Medicare-allowable cost includes both direct patient cost (for example, emergency department, operating room, and intensive care) and indirect general service cost (for example, administration, laundry, and pharmacy) but excludes items not related to the patient care provided by the hospital, such as services of the gift shop and private physicians' offices. We obtained the cost data from line 202 in column 8 of the worksheet mentioned above.

LIMITATIONS There are a number of important limitations to consider. First, the Medicare cost report does not separate costs by inpatient and outpatient hospital setting. The charge-to-cost ratio may vary for inpatient and outpatient care. Second, the Medicare cost report provides aggregate information on the markups and does not report data on the markup for specific insurers. If a hospital offers a discount to certain categories of uninsured patients, its cost report does not report this information. Third, Medicare cost reports are based on administrative records submitted by hospitals, so there may be human error and systematic inaccuracies within the data. Fourth, before 2011 a slightly different format was used in the Medicare cost reports that could complicate comparisons to earlier years. Finally, not all hospitals have the same cost structure, and there is significant cost variation across hospitals.[14–16] The charge-to-cost ratio, which is influenced by individual hospitals' cost control practices, therefore, is not a perfect measure of the extent of overcharging.

Study Results

DESCRIPTIVE STATISTICS On average, US hospital charges were 3.4 times the Medicare-allowable cost (hereafter referred to simply as cost) in 2012. In other words, when the hospital incurs $100 of Medicare-allowable costs, the hospital charges $340. Over time, hospital markups have

increased. The increases began in the late 1980s and started to accelerate in 2000.[1] In 1984 the average charge-to-cost ratio was 1.35.[1] In 2004 and 2011 the average charge-to-cost ratio was 3.07 and 3.30, respectively. The markup in 2012, therefore, represents a 10 percent increase from 2004, and 3 percent increase from 2011.[1] In 2012 the average charge-to-cost ratio (3.4) was greater than the median (3.1), which suggests that the distribution was skewed to the right. The mode (or the most common ratio) was 2.4. The 10 percent lowest-charging hospitals had charge-to-cost ratios below 1.5, while the upper 10 percent had ratios above 5.7. In this study we focused on the fifty hospitals or approximately the 1 percent with the highest charge-to-cost ratios.

Fifty Hospitals With The Highest Charge-To-Cost Ratios

Most hospitals are in the 1.5–4.0 range (Exhibit 1). However, the tail of this distribution is quite long, and the fifty hospitals with the highest ratios charge, on average, 10.1 times their cost. This means that they are charging markups of more than 1,000 percent. These hospitals are outliers in the distribution. The minimum charge-to-cost ratio among them is 9.2—more than three standard deviations above the average for all hospitals. The maximum charge-to-cost ratio is 12.6—more than five standard deviations above the average for all hospitals.[17]

For-profit hospitals are disproportionately represented in these fifty hospitals—forty-nine (98 percent) are for profit, compared to 30 percent in the overall sample (Exhibit 2). These fifty hospitals are more likely to be located in urban areas (86 percent versus 68 percent for all hospitals) but less likely to be teaching hospitals (18 percent versus 24 percent for all hospitals).

These fifty hospitals are also more likely to be affiliated with a health care system (94 percent versus 56 percent for all hospitals).[18] Just one for-profit hospital system (Community Health Systems) operates half of the fifty hospitals with the highest markups (Exhibit 3). Hospital Corporation of America operates more than one-quarter of them.

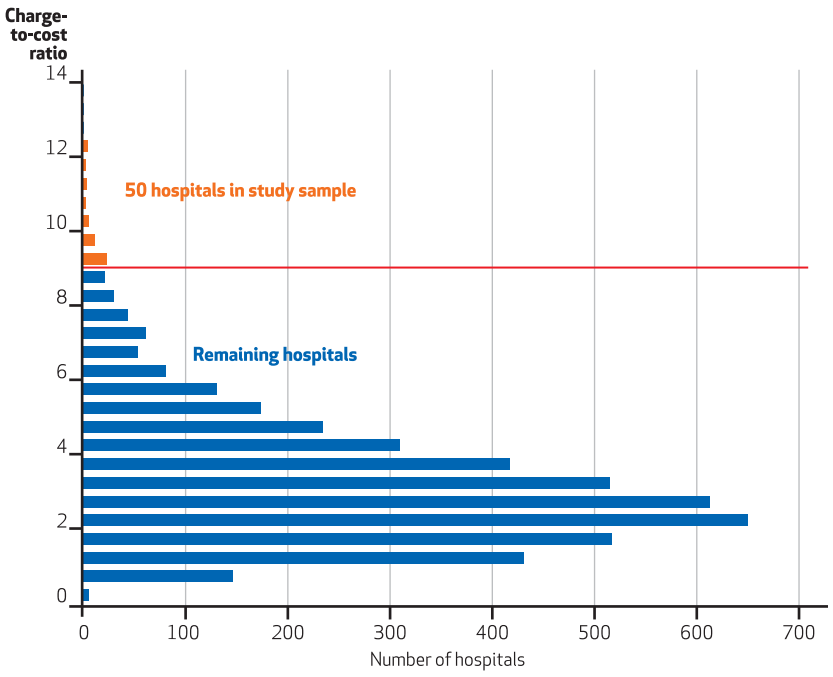
The fifty hospitals are distributed across thirteen states, with 76 percent located in southern states (Exhibit 4). Florida has 40 percent of the fifty hospitals with the highest markups. It is worth noting that among these thirteen states, only California and New Jersey have state legislation that requires for-profit hospitals to offer price discounts to eligible uninsured patients.[19] As a result, uninsured patients receiving care in the forty-six hospitals outside of California and New Jersey are able to charge approximately ten times cost, unless these hospitals voluntarily offer price discounts. The names of the fifty hospitals, state, ownership, urban or rural location, numbers of beds, numbers of residents, and charge-to-cost ratios are listed in the online Appendix.[20]

Discussion

Markups of the fifty hospitals with the highest charge-to-cost ratios are 9.2–12.6 times the Medicare-allowable costs. While publicly insured patients typically pay comparatively close to actual cost, uninsured patients, out-of-network patients, and casualty and workers' compensation insurers do not have comparable bargaining or regulatory power and thus are charged either the full amount or a high percentage of the full amount, unless the hospitals voluntarily offer discounts. Hospitals' high markups, therefore, subject many vulnerable patients to exceptionally high medical bills, which often leads to personal bankruptcy or the avoidance of needed medical services.[1,21,22] Furthermore, privately insured patients may also pay a greater premium because high markups give hospitals greater

EXHIBIT 1

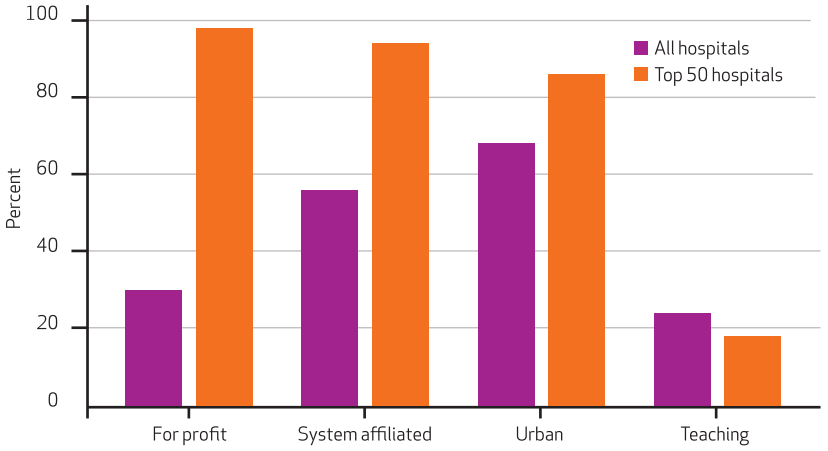
Hospitals' Charge-To-Cost Ratios, 2012



SOURCE Authors' analysis of Healthcare Cost Report Information System (HCRIS) computer files obtained from the Centers for Medicare and Medicaid Services (CMS) for 2012. **NOTES** Each bar shows the number of hospitals that fall into the indicated range or "bin" on the spectrum of observed charge-to-cost ratios, starting with 0.0 to 0.4 and progressing upward in increments of 0.5. The orange bars represent the fifty hospitals with the highest charge-to-cost ratios. The red line marks the minimum charge-to-cost ratio among these fifty hospitals.

EXHIBIT 2

Characteristics Of The Fifty Hospitals With The Highest Charge-To-Cost Ratios And All Hospitals, 2012



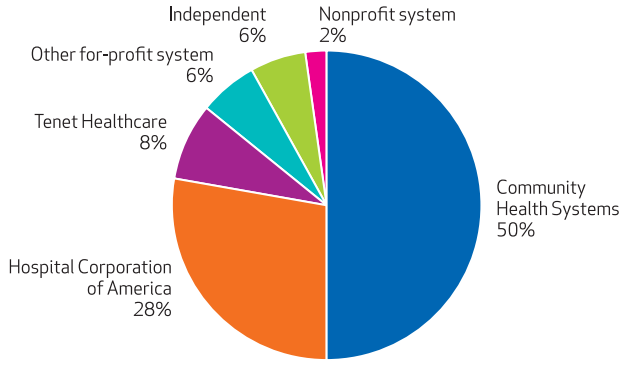
SOURCE Authors' analysis of Healthcare Cost Report Information System (HCRIS) computer files obtained from the Centers for Medicare and Medicaid Services (CMS) for 2012.

bargaining power with private insurers in price negotiations. As a result, high markups play a role in the rise of overall health care spending.[5]

Hospital executives have suggested that the high charge-to-cost ratio is partially attributable to the slow rate growth in Medicare and Medicaid spending and the need to have operating surpluses in order to remain in business. Clearly, hospitals need to receive sufficient revenue to remain in business, and having revenues that are above costs is necessary. This argument, however, cannot completely explain the wide variation in the charge-to-cost ratio shown in Exhibit 1 or why some hospitals are charging ten times their own costs.

EXHIBIT 3

Distribution Of The Fifty Hospitals With The Highest Charge-To-Cost Ratios, By System Affiliation, 2012



SOURCE Authors' analysis of Healthcare Cost Report Information System (HCRIS) computer files obtained from the Centers for Medicare and Medicaid Services (CMS) for 2012.

Prices are rarely discussed with patients before treatment because of patients' lack of time, ability, and knowledge; physicians' professional norms against discussing fees; the complexity of hospital accounting; and the lack of price transparency.[9] Consider the patient wanting to compare hospital prices before an elective surgery. That person would need to know differences in quality and patient satisfaction across the potential hospitals for the specific procedure. The patient would also want to compare prices across the potential hospitals using the charge-master file and the Medicare cost report. Both documents are extremely complex, and a comparison is impossible unless the patient knows exactly which services will be ordered and how the services will be coded. Some hospitals might unbundle services (creating more categories of billable services to maximize revenue), which makes it more challenging for patients to precisely estimate a price for the total service. Furthermore, the price and quality of physicians and other clinicians caring for the patient would need to be compared as well. Knowing all of the relevant information about the hospital without knowing the price and quality of physician services is like purchasing a suit and only knowing the price of the pants. The patient, however, usually does not know all of the physicians who will provide care, because some physicians are in network and others are out of network, a factor that could significantly affect the actual amount the patient would pay.

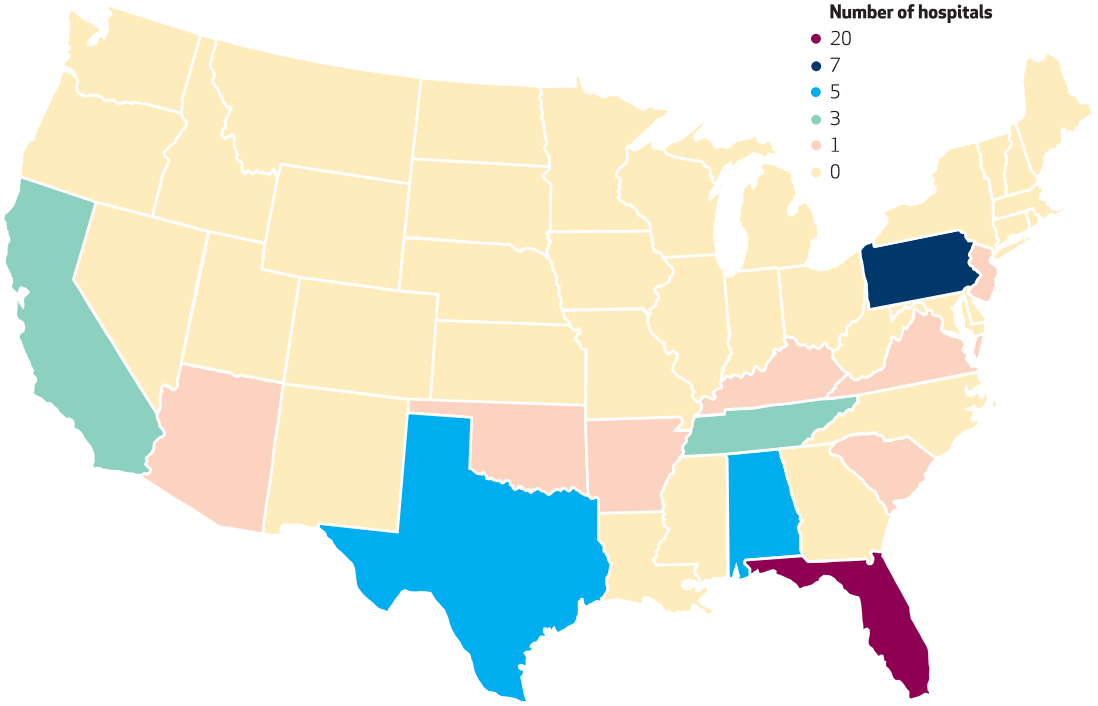
Simply speaking, a patient wanting to compare hospital prices faces a substantial information asymmetry for an elective procedure, and the time necessary to conduct price and quality comparisons is certainly not available in most medical emergencies. The result is a market failure that forces uninsured patients, out-of-network patients, and casualty and workers' compensation insurers to pay charges that are marked up multiple times above costs and are much higher than what publicly insured and privately insured in-network patients pay. The current regulatory environment, unfortunately, does little to correct this market failure. The extent of this market failure is especially salient in these fifty hospitals.

Policy Implications

There are several possible solutions to this market failure. First, federal and state policy makers could require hospitals to post their overall charge-to-cost ratios on their website, or the Medicare program could post them. This information is currently available in the Medicare cost reports, but it is extremely difficult for the public

EXHIBIT 4

Distribution Of The Fifty Hospitals With Highest Charge-To-Cost Ratios, By State, 2012



SOURCE Authors' analysis of Healthcare Cost Report Information System (HCRIS) computer files obtained from the Centers for Medicare and Medicaid Services (CMS) for 2012.

to obtain. This public disclosure would reduce the information asymmetry of hospital price faced by patients and may deter hospitals from establishing excessively high markups.

For this to be truly effective, hospitals would need to be required to implement a uniform markup across all hospital departments. Currently, the markup varies substantially across medical services in the same hospital, and an overall hospital-level charge-to-cost ratio might not reflect the extent of markup for a specific patient. For example, among the fifty hospitals analyzed in this study, the average charge-to-cost ratio for anesthesiology is 112, for diagnostic radiology it is 15, and for nursery it is 3. To overcome this limitation, one option is to require all hospitals to use a uniform charge-to-cost ratio for all services and disclose this ratio. This approach, by reducing the variation of markups across services, would make it easier for patients to compare hospital prices.

This would require a major accounting effort. Hospitals have established their chargemaster rates to maximize revenue, initially to maximize revenues in the Medicare programs and now in the private sector. In the current system, hospitals incur substantial general indirect service cost and must allocate it to each individual direct service category. Because the allocation metric differs among hospitals, the cost base for each service category is not perfectly comparable across hospitals. Therefore, to make the markup constant for all services would be a complex accounting process.

These technical solutions may not actually solve the problem anyway. Public disclosure of hospital markup information is useful only if patients have a real option to choose among competing hospitals. This is clearly not the case when patients are in medical emergencies. Even for elective services, the ability to comparison shop is severely limited by imperfect information about what specific services will be ordered by the physicians, what physicians will be providing the services, and how the services will be billed (for example, bundled or unbundled).

A second option is to legislate a maximum markup over cost that a hospital can charge to any patient, similar to that proposed by Barak Richman, Mark Hall, and Kevin Schulman and several other previous studies.[1,3,9] The legislature could say that the most a hospital can charge a patient is X times the cost of treating that patient. This would reduce the level of markups for the most extreme cases but would do little to change the behavior of most hospitals. Alternatively, the

legislature could decide that the maximum rate a hospital can charge is based on the rate negotiated with a health plan or the rate Medicare pays. The legislation could allow the hospital to charge a slightly higher rate than the health plan or Medicare will reimburse. At the federal level, this rate limit could be implemented through a modification of Medicare participation conditions for hospitals.

Existing laws in some states use a variant of this approach to protect uninsured patients against high hospital charges. California's Hospital Fair Pricing Act, for example, requires all California hospitals to charge uninsured patients with an annual household income below 350 percent of the federal poverty level no more than what Medicare would pay.[8] In most hospitals, the Medicare rate is within 90 percent of costs, not 200 percent or, in the case of these fifty hospitals, 1,000 percent of costs.[6] This approach is likely to benefit not only uninsured patients, out-of-network patients, and casualty and workers' compensation insurers, but also in-network patients. As hospitals become less able to generate high markups from out-of-network patients, they will be motivated to join networks and agree on lower negotiated prices. Using a similar idea, the Medicare program requires hospitals to limit their charges to Medicare Advantage plans to the Medicare fee-for-service (FFS) levels. This protection greatly strengthens Medicare Advantage plans' negotiating position.[5,23]

The ACA contains provisions requiring nonprofit hospitals to discount their charges for eligible uninsured patients to no more than the amount paid by any commercial health plan. The protection provided by the ACA, however, is limited. First, nonprofit hospitals retain discretion to determine their own patient eligibility criteria for discounted charges. Second, the law is silent on hospital pricing practices for out-of-network patients and casualty and workers' compensation insurers. Third, for-profit hospitals are not required to offer discounted prices to uninsured patients. This study shows that for-profit hospitals are more likely than others to have extreme markups.

The third solution is for legislatures to require all insurers to use the same payment system but not necessarily pay the same rates. In this payment system, all private and public insurance plans would pay hospitals according to a single payment method such as diagnosis-related groups. The actual rates could differ from insurer to insurer, but all insurers would base their rates on the same payment system. This would facilitate price comparisons since the negotiated prices are all based on a single payment method. Besides facilitating price comparisons and price negotiations, having a single payment system has the added benefit of lowering administrative costs to both insurers and providers.

One variant is to have the fee schedule negotiated periodically between representatives of health insurers and representatives of health care providers.[6,24] Several countries, such as Germany, Japan, and Switzerland, use this type of system.[6,24] Another variant is to have the government determine the rate—a system that the State of Maryland has been using for four decades.[25] To implement these two variants, admittedly, would require fundamental changes to the current payment system and would be subject to considerable political challenges. While the larger political challenge is to get all insurers to pay the same rates, an easier political challenge might be to get all insurers to use the same payment system.

40%

In Florida

Of the fifty hospitals with the highest markups, 40 percent are in Florida.

Conclusion

We found that fifty US hospitals had charges that, on average, were ten times their Medicare-allowable cost. These hospitals' charge-to-cost ratios were more than three standard deviations above the US average, which suggests that they are outliers and warrant additional scrutiny. Our analysis showed that forty-nine of these fifty hospitals are for-profit, forty-six are owned by for-profit hospitals systems, twenty-five are in just one for-profit system, and twenty are in Florida. These hospitals are outliers—the typical hospital charged 3.4 times its Medicare-allowable costs, 20 percent of hospitals charged less than twice their cost, and hospitals in Maryland had markups of less than 1.5—lower than those of hospitals in any other state.

The main causes of these extremely high markups are a lack of price transparency and negotiating power by uninsured patients, out-of-network patients, casualty and workers' compensation insurers, and even in-network insurers. Federal and state policy makers need to recognize the extent of hospital markups and consider policy solutions to contain them. Options include limitations on the overall charge-to-cost ratio, limitations on the charge-to-cost ratio for specific services, some unified form of all-payer rate setting, and mandated price disclosure. ■

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NOTES

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20 To access the Appendix, click on the Appendix link in the box to the right of the article online.

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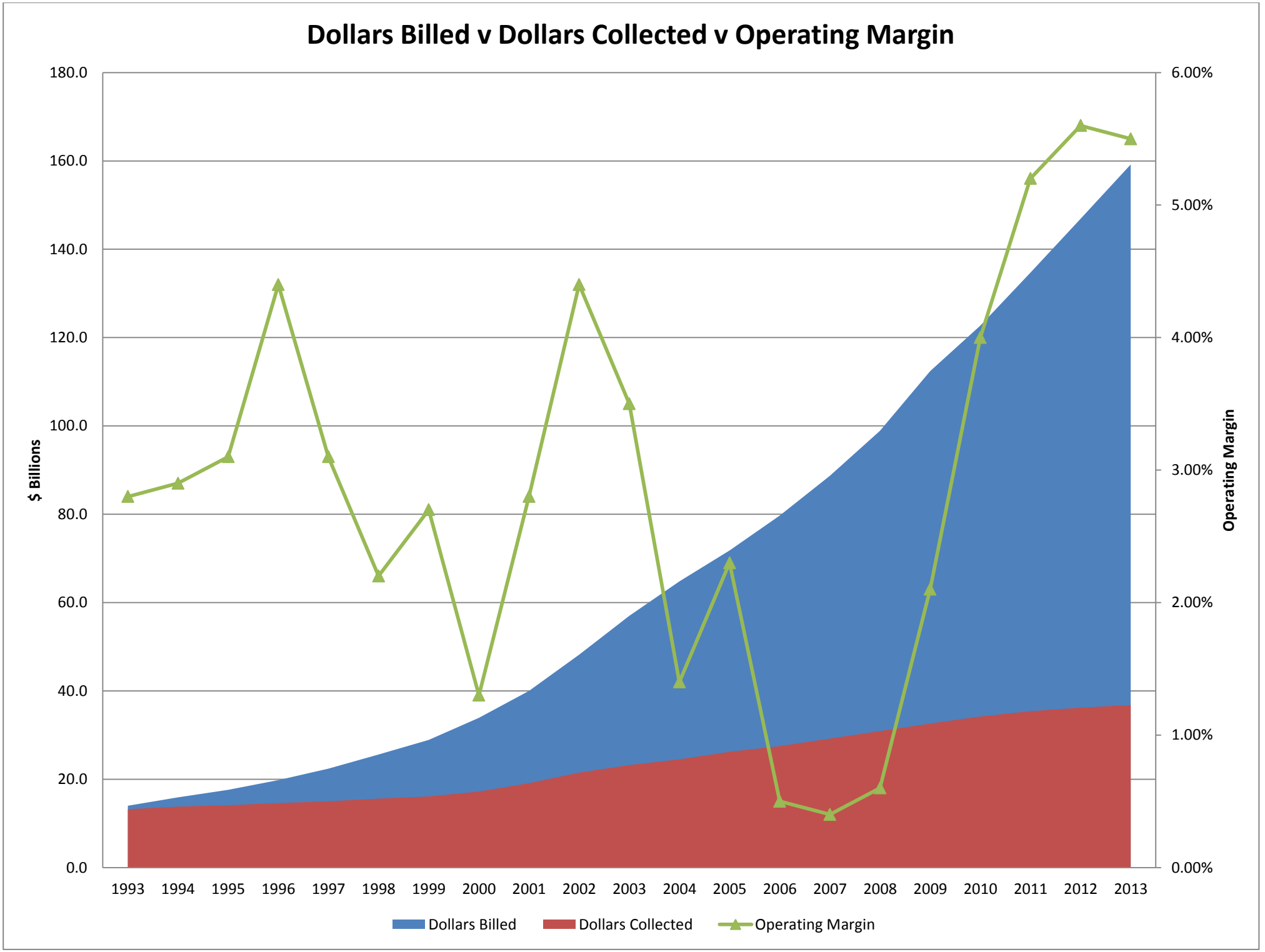
Dollars Billed v Dollars Collected v Operating Margin
180.0
160.0
140.0
120.0
100.0
80.0
60.0
40.0
20.0
0.0
$ Billions
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Operating Margin
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
Dollars Billed
Dollars Collected
Operating Margin

APPENDIX: List Of The 50 Hospitals With The Highest Charge-To-Cost Ratios, 2012

Rank	Hospital Name (Affiliated System)	State	Ownership	Location	Beds	Teaching	Ratio
1	North Okaloosa Medical Center (CHS)	FL	For-profit	Urban	110	N	12.6
2	Carepoint Health-Bayonne Hospital (Carepoint)	NJ	For-profit	Urban	268	N	12.6
3	Bayfront Health Brooksville (CHS)	FL	For-profit	Urban	244	N	12.5
4	Paul B Hall Regional Medical Center (CHS)	KY	For-profit	Rural	72	N	12.5
5	Chestnut Hill Hospital (CHS)	PA	For-profit	Urban	129	Y	11.9
6	Gadsden Regional Medical Center (CHS)	AL	For-profit	Rural	300	N	11.9
7	Heart of Florida Regional Medical Center (CHS)	FL	For-profit	Urban	194	N	11.5
8	Orange Park Medical Center (HCA)	FL	For-profit	Urban	297	N	11.4
9	Western Arizona Regional Medical Center (CHS)	AZ	For-profit	Urban	139	N	11.4
10	Oak Hill Hospital (HCA)	FL	For-profit	Urban	236	N	11.0
11	Texas General Hospital	TX	For-profit	Urban	41	N	10.8
12	Fort Walton Beach Medical Center (HCA)	FL	For-profit	Urban	257	N	10.6
13	Easton Hospital (CHS)	PA	For-profit	Urban	221	Y	10.4
14	Brookwood Medical Center (TENET)	AL	For-profit	Urban	631	N	10.3
15	National Park Medical Center (Capella Healthcare)	AR	For-profit	Urban	163	N	10.3
16	St. Petersburg General Hospital (HCA)	FL	For-profit	Urban	215	Y	10.2
17	Crozer Chester Medical Center (Crozer-Keystone)	PA	Nonprofit	Urban	583	Y	10.1
18	Riverview Regional Medical Center (CHS)	AL	For-profit	Urban	281	N	10.0
19	Regional Hospital of Jackson (CHS)	TN	For-profit	Rural	115	N	9.9
20	Sebastian River Medical Center (CHS)	FL	For-profit	Urban	154	N	9.9
21	Brandywine Hospital (CHS)	PA	For-profit	Urban	169	N	9.9
22	Osceola Regional Medical Center (HCA)	FL	For-profit	Urban	257	N	9.8
23	Decatur Morgan Hospital - Parkway Campus	AL	For-profit	Urban	120	N	9.8
24	Medical Center of Southeastern Oklahoma (CHS)	OK	For-profit	Rural	148	Y	9.8
25	Gulf Coast Medical Center (HCA)	FL	For-profit	Urban	176	N	9.8

Rank	Hospital Name	State	Ownership	Location	Beds	Teaching	Ratio
26	South Bay Hospital (HCA)	FL	For-profit	Urban	112	N	9.7
27	Fawcett Memorial Hospital (HCA)	FL	For-profit	Urban	238	N	9.7
28	North Florida Regional Medical Center (HCA)	FL	For-profit	Urban	335	N	9.6
29	Doctors Hospital of Manteca (TENET)	CA	For-profit	Urban	73	N	9.6
30	Doctors Medical Center (TENET)	CA	For-profit	Urban	445	Y	9.6
31	Lawnwood Regional Medical Center & Heart Institute (HCA)	FL	For-profit	Urban	365	N	9.6
32	Lakeway Regional Hospital (CHS)	TN	For-profit	Urban	135	N	9.6
33	Brandon Regional Hospital (HCA)	FL	For-profit	Urban	398	N	9.6
34	Hahnemann University Hospital (TENET)	PA	For-profit	Urban	496	Y	9.5
35	Phoenixville Hospital (CHS)	PA	For-profit	Urban	137	N	9.5
36	Stringfellow Memorial Hospital (CHS)	AL	For-profit	Urban	125	N	9.5
37	Lehigh Regional Medical Center (CHS)	FL	For-profit	Urban	88	N	9.5
38	Southside Regional Medical Center (CHS)	VA	For-profit	Urban	300	N	9.5
39	Twin Cities Hospital (HCA)	FL	For-profit	Urban	59	N	9.5
40	Olympia Medical Center	CA	For-profit	Urban	204	N	9.4
41	Springs Memorial Hospital (CHS)	SC	For-profit	Rural	193	N	9.4
42	Regional Medical Center Bayonet Point (HCA)	FL	For-profit	Urban	272	N	9.4
43	Dallas Regional Medical Center (CHS)	TX	For-profit	Urban	176	N	9.4
44	Laredo Medical Center (CHS)	TX	For-profit	Urban	327	N	9.3
45	Bayfront Health Dade City (CHS)	FL	For-profit	Urban	120	N	9.3
46	Pottstown Memorial Medical Center (CHS)	PA	For-profit	Urban	193	N	9.3
47	Dyersburg Regional Medical Center CHS)	TN	For-profit	Rural	95	N	9.2
48	South Texas Health System (Universal Health Services)	TX	For-profit	Urban	816	Y	9.2
49	Kendall Regional Medical Center (HCA)	FL	For-profit	Urban	412	Y	9.2
50	Lake Granbury Medical Center (CHS)	TX	For-profit	Rural	43	N	9.2

SOURCE: Authors' analysis of Healthcare Cost Report Information System (HCRIS) computer files obtained from the Centers for Medicare and Medicaid Services for 2012.

Approved But Not Licensed Beds (6/15/2015)

				APPROVED													
				# CON/ Exemption/	Net Beds	Acute Care	LTC Hosp.	NICU		Psychiatric			Substance Abuse			Rehabil-
	Profit Status	Facility Name	City	Notification	Added	Beds	Beds	Level II	Level III	Adult	Child/ Adol	IRTF	Adult	Child/ Adol	SNU	itation
DISTRICT 1																
		Subdistrict 2- Walton County														
R	NP	SACRED HEART HOSPITAL ON THE EMERALD COAST	Miramar Beach	N140040	18	18										
DISTRICT 2																
		Subdistrict 1 - Bay County														
	FP	GULF COAST REGIONAL MEDICAL CENTER	Panama City	N140042	-2	-2										
		Subdistrict 1 - Franklin County														
R	G	GEORGE E. WEEMS MEMORIAL HOSPITAL	Apalachicola	N1000021	-25	-25										
R	G	GEORGE E. WEEMS MEMORIAL HOSPITAL	Apalachicola	N1000021	25	25										
		Subdistrict 2 - Leon County														
	FP	SELECT SPECIALTY HOSPITAL - TALLAHASSEE, INC.	Tallahassee	N120048	16		16									

Approved But Not Licensed Beds (6/15/2015)

				APPROVED													
				# CON/	Net	Acute	LTC	NICU		Psychiatric			Substance Abuse			
	Profit Status	Facility Name	City	Exemption/ Notification	Beds Added	Care Beds	Hosp. Beds	Level II	Level III	Adult	Child/ Adol	IRTF	Adult	Child/ Adol	SNU	Rehabil-itation
DISTRICT 3																	
		Subdistrict 1 - Columbia County															
	FP	LAKE CITY MEDICAL CENTER	Lake City	N130006	32	32										
R	FP	SHANDS LAKE SHORE REGIONAL MEDICAL CENTER	Lake City	N1100041	-7	-7										
		Subdistrict 2 - Alachua County															
T	NP	UF HEALTH SHANDS HOSPITAL	Gainesville	N120037	8			8								
T	NP	UF HEALTH SHANDS HOSPITAL	Gainesville	N120038	8				8							
T	NP	UF HEALTH SHANDS HOSPITAL	Gainesville	N140015	240	240										
	NP	UF HEALTH SHANDS PSYCHIATRIC HOSPITAL		N150007						2			-2			
	NP	UF HEALTH SHANDS REHABILITATION HOSPITAL	Gainesville	N150023	10											10
		Subdistrict 2 - Levy County															
	FP	SUWANEE RIVER COMMUNITY HOSPITAL	Chiefland	10232	28	28										
		Subdistrict 4 - Marion County															
	FP	MUNROE REGIONAL MEDICAL CENTER	Ocala	E1100016	10			10								
	FP	OCALA REGIONAL MEDICAL CENTER	Ocala	N140002	14	14										
	FP	OCALA REGIONAL MEDICAL CENTER	Ocala	N140024	8	8										
	NP	THE CENTERS, INC.	Ocala	E140018	8					8						
	FP	WEST MARION COMMUNITY HOSPITAL	Ocala	N140003	24	24										
		Subdistrict 6 - Hernando County															
	FP	OAK HILL HOSPITAL	Brooksville	N140039	18	18										
	FP	SPRINGBROOK HOSPITAL	Brooksville	E110007	24					24						
	FP	SPRINGBROOK HOSPITAL	Brooksville	E150011	12					12						
		Subdistrict 7 - Lake County															
	NP	LEESBURG REGIONAL MEDICAL CENTER	Leesburg	N1000019	20	20										
	NP	LEESBURG REHABILITATION HOSPITAL	Leesburg	10218	-22											-22
		Subdistrict 7 - Sumter County															
	NP	THE VILLAGES REGIONAL HOSPITAL	The Villages	10218	22											22
	NP	THE VILLAGES REGIONAL HOSPITAL	The Villages	N120030	100	100										

Approved But Not Licensed Beds (6/15/2015)

				APPROVED													
				# CON/	Net	Acute	LTC	NICU		Psychiatric			Substance Abuse				
				Exemption/	Beds	Care	Hosp.	Level	Level		Child/			Child/			Rehabil-
	Profit Status	Facility Name	City	Notification	Added	Beds	Beds	II	III	Adult	Adol	IRTF	Adult	Adol	SNU	itation
DISTRICT 4																	
		Subdistrict 1 - Duval County															
	NP	SHANDS JACKSONVILLE MEDICAL CENTER, INC.	Jacksonville	10198	92	92											
		Subdistrict 1 - Nassau County															
R	NP	BAPTIST MEDICAL CENTER - NASSAU	Fernandina Beach	N130014	2	2											
		Subdistrict 2 - Clay County															
	FP	ORANGE PARK MEDICAL CENTER	Orange Park	10160	20												20
	FP	ORANGE PARK MEDICAL CENTER	Orange Park	E140005	26					26							
		Subdistrict 2 - Duval County															
	FP	WEST JACKSONVILLE MEDICAL CENTER, INC.	Jacksonville	10059	85	85											
		Subdistrict 3 - Duval County															
	NP	BAPTIST MEDICAL CENTER DOWNTOWN	Jacksonville	N1100002				-7	7								
	NP	BAPTIST MEDICAL CENTER JACKSONVILLE	Jacksonville	N140030	8				8								
	NP	BAPTIST MEDICAL CENTER JACKSONVILLE	Jacksonville	N140041	-8	-8											
	NP	BAPTIST MEDICAL CENTER JACKSONVILLE	Jacksonville	N150019	12	12											
	NP	BAPTIST MEDICAL CENTER JACKSONVILLE	Jacksonville	E150002	3						3						
	NP	BAPTIST MEDICAL CENTER SOUTH	Jacksonville	N140007	18	18											
	NP	BAPTIST MEDICAL CENTER SOUTH	Jacksonville	N140021	2	2											
	NP	BAPTIST MEDICAL CENTER SOUTH	Jacksonville	N140028	24	24											
	NP	BROOKS REHABILITATION HOSPITAL	Jacksonville	E150013	3												3
	NP	MAYO CLINIC	Jacksonville	N120016	57	57											
	FP	RIVER POINT BEHAVIORAL HEALTH	Jacksonville	E150009						-10	10						
	NP	ST. VINCENTS MEDICAL CENTER SOUTHSIDE	Jacksonville	N130028	1	1											
		Subdistrict 4 - Flagler County															
	FP	PALM COAST BEHAVIORAL HEALTH, LLC		10220	63					63							
		Subdistrict 4 - Volusia County															
	NP	FLORIDA HOSPITAL MEMORIAL MEDICAL CENTER	Daytona Beach	E140031	16			16									
	G	HALIFAX HEALTH MEDICAL CENTER	Daytona Beach	E130004	5				5								
	G	HALIFAX HEALTH MEDICAL CENTER	Daytona Beach	N140047	5				5								
	G	HALIFAX HEALTH MEDICAL CENTER	Daytona Beach	N140048	-24	-24											
	G	HALIFAX HEALTH MEDICAL CENTER	Daytona Beach	E150005	14					14							
		Subdistrict 5 - Volusia County															
	NP	FLORIDA HOSPITAL DELAND	Daytona Beach	N140035	8	8											

Approved But Not Licensed Beds (6/15/2015)

				APPROVED													
				# CON/ Exemption/	Net Beds	Acute Care	LTC Hosp.	NICU		Psychiatric			Substance Abuse				
	Profit Status	Facility Name	City	Notification	Added	Beds	Beds	Level II	Level III	Adult	Child/ Adol	IRTF	Adult	Child/ Adol	SNU	Rehabil-itation	
DISTRICT 5																	
		Subdistrict 1 - Pasco County															
	NP	FLORIDA HOSPITAL AT CONNERTON LONG TERM ACUTE CARE HOSPITAL	Land O' Lakes	N140014	25		25										
	FP	MEDICAL CENTER OF TRINITY	Trinity	10178	12			12									
	FP	MEDICAL CENTER OF TRINITY	Trinity	N140046	21	21											
	FP	MEDICAL CENTER OF TRINITY	Trinity	N150012	-6	-6											
	NP	MORTON PLANT NORTH BAY HOSPITAL	New Port Richey	E120011	10											10	
	NP	MORTON PLANT NORTH BAY HOSPITAL	New Port Richey	N120036	-14	-14											
		Subdistrict 2 - Pasco County															
	NP	FLORIDA HOSPITAL ZEPHYRHILLS	Zephyrhills	N140022	1	1											
	NP	MORTON PLANT NORTH BAY HOSPITAL RECOVERY CENTER	Lutz	N150017						-9	9						
		Subdistrict 3 - Pinellas County															
	NP	FLORIDA HOSPITAL NORTH PINELLAS	Tarpon Springs	N150020		-14									14		
	FP	KINDRED HOSPITAL BAY AREA-ST. PETERSBURG	St.Petersburg	N150017	31										31		
	NP	MORTON PLANT HOSPITAL	Clearwater	N110009	5			5									
	NP	ST. ANTHONY'S HOSPITAL	St.Petersburg	N150001	-2										-2		
	NP	ST. ANTHONY'S HOSPITAL	St.Petersburg	N150003		28									-28		

Approved But Not Licensed Beds (6/15/2015)

				APPROVED													
				# CON/	Net	Acute	LTC	NICU		Psychiatric			Substance Abuse			
	Profit Status	Facility Name	City	Exemption/ Notification	Beds Added	Care Beds	Hosp. Beds	Level II	Level III	Adult	Child/ Adol	IRTF	Adult	Child/ Adol	SNU	Rehabil-itation
DISTRICT 6																	
		Subdistrict 1 - Hillsborough County															
	FP	BRANDON REGIONAL HOSPITAL	Brandon	N140004	40	40										
	NP	FLORIDA HOSPITAL TAMPA	Tampa	N140037	18	18										
	NP	ST. JOSEPH'S HOSPITAL	Tampa	9833	-90	-90										
	NP	ST. JOSEPH'S HOSPITAL, INC.	Riverview	9833	90	90										
	FP	SOUTH BAY HOSPITAL	Sun City	N15004	26	26										
T	NP	TAMPA GENERAL HOSPITAL	Tampa	N140018	-22					-22						
T	NP	TAMPA GENERAL HOSPITAL	Tampa	N140033	16	16										
		Subdistrict 2 - Polk County															
	FP	BARTOW REGIONAL MEDICAL CENTER	Bartow	N1000035	50	50										
	NP	LAKELAND REGIONAL MEDICAL CENTER	Lakeland	10164	32											32
	NP	LAKELAND REGIONAL MEDICAL CENTER	Lakeland	E0900015	18				18							
	FP	LAKE WALES MEDICAL CENTER	Lake Wales	E140021		-18				18						
		Subdistrict 3 - Manatee County															
	FP	SUNCOAST BEHAVIORAL HEALTH CENTER	Bradenton	N140025	-4							-4				
	FP	MANATEE MEMORIAL HOSPITAL	Bradenton	10179	15				15							
	FP	MANATEE MEMORIAL HOSPITAL	Bradenton	N150003	1	25							-24			
	NP	MANATEE GLENS HOSPITAL & ADDICTION CENTER	Bradenton	E140009	3								3			

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				APPROVED													
				# CON/	Net	Acute	LTC	NICU		Psychiatric			Substance Abuse			
	Profit Status	Facility Name	City	Exemption/ Notification	Beds Added	Care Beds	Hosp. Beds	Level II	Level III	Adult	Child/ Adol	IRTF	Adult	Child/ Adol	SNU	Rehabil-itation
DISTRICT 7																	
		Subdistrict 1 - Brevard County															
	FP	INDIAN RIVER BEHAVIORAL HEALTH LLC		10233	74						74						
		PALM BAY HOSPITAL	Melbourne	E150017		-18				18							
		Subdistrict 2 - Orange County															
	FP	CENTRAL FLORIDA BEHAVIORAL HOSPITAL	Orlando	E150004	48					48							
T	NP	FLORIDA HOSPITAL APOPKA	Apopka	10222	50	50											
T	NP	FLORIDA HOSPITAL APOPKA	Apopka	10222	-50	-50											
T	NP	FLORIDA HOSPITAL APOPKA	Apopka	N140011	30	30											
T	NP	FLORIDA HOSPITAL APOPKA	Apopka	N150013	40	40											
T	NP	FLORIDA HOSPITAL	Orlando	N130022	-17	-17											
T	NP	FLORIDA HOSPITAL	Orlando	E130011	10												10
	NP	FLORIDA HOSPITAL EAST ORLANDO	Orlando	N150010	40	40											
	G	HEALTH CENTRAL HOSPITAL	Ocoee	N140038	50	50											
	NP	LAKESIDE BEHAVIORAL HEALTHCARE, INC.	Orlando	E140022	32					32							
	NP	NEMOURS CHILDRENS HOSPITAL	Orlando	E120009	10						10						
	NP	NEMOURS CHILDRENS HOSPITAL	Orlando	10167	9												9
	NP	NEMOURS CHILDRENS HOSPITAL	Orlando	150008	8				8								
T	NP	ORLANDO REGIONAL MEDICAL CENTER	Orlando	N120010	146	146											
	FP	SELECT SPECIALTY HOSPITAL-ORLANDO (SOUTH CAMPUS)	Orlando	N120047	24		24										
		Subdistrict 3 - Osceola County															
T	NP	FLORIDA HOSPITAL KISSIMMEE	Kissimmee	N130012	80	80											
	FP	OGLETHORPE OF ORLANDO, INC.		10170	28					28							
	FP	OGLETHORPE OF ORLANDO, INC.		10171	14								14				
	FP	POINCIANA MEDICAL CENTER	Kissimmee	N140029	46	46											
		Subdistrict 4 - Seminole County															
T	NP	FLORIDA HOSPITAL ALTAMONTE		N150005	36	36											
	FP	OVIEDO MEDICAL CENTER, LLC	Oviedo	10223	80	80											
	FP	OVIEDO MEDICAL CENTER	Oviedo	N150018	-16	-16											
	FP	SOUTH SEMINOLE HOSPITAL	Longwood	N130027						16	-16						

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				APPROVED													
				# CON/	Net	Acute	LTC	NICU		Psychiatric			Substance Abuse			
	Profit Status	Facility Name	City	Exemption/ Notification	Beds Added	Care Beds	Hosp. Beds	Level II	Level III	Adult	Child/ Adol	IRTF	Adult	Child/ Adol	SNU	Rehabil-itation
DISTRICT 8																	
		Subdistrict 2 - Collier County															
	FP	LANDMARK HOSPITAL OF SOUTHWEST FLORIDA, LLC	North Naples	10137	50		50									
	FP	PHYSICIANS REGIONAL MEDICAL CENTER - PINE RIDGE	Naples	N120011	5	5										
		Subdistrict 5 - Lee County															
	NP	GULF COAST MEDICAL CENTER, LEE MEMORIAL HEALTH	Fort Myers	N150024	7	7										
	NP	GULF COAST MEDICAL CENTER, LEE MEMORIAL HEALTH	Fort Myers	N150024	275	275										
	NP	HEALTHPARK MEDICAL CENTER	Fort Myers	N120020	70	70										
	NP	HEALTHPARK MEDICAL CENTER	Fort Myers	N120021	8			8								
	NP	HEALTHPARK MEDICAL CENTER	Fort Myers	N120022	8				8							
	FP	PARK ROYAL HOSPITAL	Fort Myers	E130002	9					9						

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				APPROVED													
				# CON/	Net	Acute	LTC	NICU		Psychiatric			Substance Abuse			
	Profit Status	Facility Name	City	Exemption/ Notification	Beds Added	Care Beds	Hosp. Beds	Level II	Level III	Adult	Child/ Adol	IRTF	Adult	Child/ Adol	SNU	Rehabil-itation
DISTRICT 9																	
		Subdistrict 1 - Indian River County															
	NP	INDIAN RIVER MEDICAL CENTER	Vero Beach	N140036	-7	-7										
		Subdistrict 2 - Martin County															
	FP	HEALTHSOUTH REHABILITATION HOSPITAL AT MARTIN HEALT	Stuart	E140015	10											10
	FP	TREASURE COAST BEHAVIORAL HEALTH, LLC		10201	7					7						
	FP	TREASURE COAST BEHAVIORAL HEALTH, LLC		E140006	53					53						
	FP	TREASURE COAST BEHAVIORAL HEALTH, LLC		E140007	20								20			
		Subdistrict 2 - St. Lucie County															
	FP	LAWNWOOD REGIONAL MEDICAL CENTER & HEART INSTITUTE	Fort Pierce	E140008	10											10
	NP	TRADITION MEDICAL CENTER	Port St. Lucie	N150021	86	86										
	NP	TRADITION MEDICAL CENTER	Port St. Lucie	N150022	4			4								
		Subdistrict 4 - Palm Beach County															
	NP	JUPITER MEDICAL CENTER	Jupiter	N1100037	45	45										
		Subdistrict 5 - Palm Beach County															
	NP	BETHESDA HOSPITAL EAST	Boynton Beach	N130032	6			6								
	FP	JFK MEDICAL CENTER	Atlantis	N140013	18	18										
	FP	JFK MEDICAL CENTER	Atlantis	N150023	28	28										

Approved But Not Licensed Beds (6/15/2015)

				APPROVED													
				# CON/	Net	Acute	LTC	NICU		Psychiatric			Substance Abuse			
	Profit Status	Facility Name	City	Exemption/ Notification	Beds Added	Care Beds	Hosp. Beds	Level II	Level III	Adult	Child/ Adol	IRTF	Adult	Child/ Adol	SNU	Rehabil-itation
DISTRICT 10																
		Subdistrict 1 - Broward County														
	FP	ATLANTIC SHORES HOSPITAL	Fort Lauderdale	10224	-42					-42						
	FP	THE SHORES BEHAVIORAL HOSPITAL, LLC	Fort Lauderdale	10224	60					60						
	G	MEMORIAL REGIONAL HOSPITAL	Hollywood	N130024						11			-11			
	G	MEMORIAL REGIONAL HOSPITAL	Hollywood	N130002	20				20							
	G	MEMORIAL REGIONAL HOSPITAL	Hollywood	N150006						-2	2					
	G	MEMORIAL REGIONAL SOUTH	Hollywood	N150016	-23	-23										
	G	MEMORIAL REGIONAL SOUTH	Hollywood	E150014	10											10
	FP	NORTHWEST MEDICAL CENTER	Margate	10189	5				5							
	FP	PLANTATION GENERAL HOSPITAL	Plantation	10235	-64	-64										
DISTRICT 11																
		Subdistrict 1 - Miami-Dade County														
	FP	HIALEAH HOSPITAL	Hialeah	E130014	-12	-12										
	NP	HOMESTEAD HOSPITAL	Homestead	E1100014	10			10								
T	G	JACKSON MEMORIAL HOSPITAL	Miami	N140027	-5	-5										
	G	JACKSON SOUTH COMMUNITY HOSPITAL	Miami	N130008	-4	-4										
	FP	KINDRED HOSPITAL-SOUTH FLORIDA-HOLLYWOOD	Hollywood	N140031	-5		-35								30	
T	FP	LARKIN COMMUNITY HOSPITAL	South Miami	E1100004	12					12						
T	FP	LARKIN COMMUNITY HOSPITAL	South Miami	E120003						-10	10					
T	FP	LARKIN COMMUNITY HOSPITAL	South Miami	N150011		4				-4						
	FP	MERCY HOSPITAL A CAMPUS OF PLANTATION GENERAL HOSPITAL	Miami	N130026	15	15										
	FP	SELECT SPECIALTY HOSPITAL - MIAMI	Miami	N0700002	24		24									
	FP	SOUTH MIAMI HOSPITAL, INC.	South Miami	N130025		-12		12								
		STATE OF FLORIDA TOTALS			2,782	1,858	104	84	107	362	102	-4			45	124

TEXAS VS FLORIDA		
Comparison of Medical Schools		
	TX	**FL**
Teaching Hospitals		
# Teaching Hospitals[1]	18	12
Avg State Funding for Teaching Hospitals	Pending data from TX	$53,096,608
Avg State Funding per Teaching Hospitals	Pending data from TX	$4,424,717.33
Residency Slots		
# ACGME Residency Slots Filled (AAMC, 2013)[2]	7,204	3,632
# Medical School Graduates in 2015	1,667	1,201
# GME First-Year Slots available to 2015 Graduates	1,882	1,112
Avg State Funding per Residency Slot (State Contribution)	$13,798	$20,242
Percentage of Medical School Graduates Staying In-State for Residency (AAMC, 2013)[3]	59.40%	49.80%
Medical Schools		
# Medical Schools	9	9
Public	8	6
Private	1	3
Avg State Funding to Medical Schools	$224,574,834.00	$48,554,250.50
Public	$186,574,834.00	$48,554.250.50
Private	$38,000,000.00	$0.00
Enrollment in Medical Schools (AAMC, 2013)	7,135	4,781
Medical Degrees Awarded (FY 2013-14)	1418	662
Public	1227	462
Private	191	200
Avg Passage Rate for US Medical Licensing Exam – Step 1, Step 2 Clinical Knowledge and Clinical Skills	97%	97%
Public	96%	97%
Private	98%	98%

[1] This includes both public and private.
[2] This includes both public and private.
[3] UM (74 in-state and 117 out-of-state) 39% in-state.

TEXAS VS FLORIDA		
Comparison of Graduate Medical Education (GME)		
	TX	**FL**
Teaching Hospital Profile[1]	• 18 teaching hospitals • 11 are Level 1 trauma centers • MD Anderson does not have a Level 1 Trauma Center	• 12 teaching hospitals • 5 are Level 1 trauma centers • Shands UF has a Level 1 trauma center
Demographics[2]	• 16.8 % of the population is on Medicaid	• 17.5% of the population is on Medicaid
Coordination of Education and Healthcare	• The Texas Higher Education Coordinating Board was tasked by the Legislature with providing An Assessment of the Opportunities for Graduates of Texas Medical Schools to Enter Graduate Medical Education in Texas, and include those findings in a strategic plan.	• No specific coordination of higher education governmental entities or medical schools with residency programs. • Florida used to have a Graduate Medical Education Committee, which was eliminated by the Legislature in 2010.
Ratio Goal[3]	• The Texas Higher Education Coordinating Board has a stated goal of 1.1 : 1 GME slots to medical school graduates. • The 1.1 : 1 ratio - for every 100 medical school graduates, the state aims for 110 open first year residency slots. This keeps more graduates in the state and provides extra spots to attract international and out-of-state graduates to Texas	None.
Turnover[4]	• Texas retains 59.4% of its medical school graduates. • Texas retains 57.9% of its GME resident physicians.	• Florida retains 49.8% of its medical school graduates. • Florida retains 58.7% of its GME resident physicians.

[1] The presence of a trauma center affects health outcome metrics.

[2] According to the Medicare Hospital Quality Chartbook, Performance Report on Outcome Measures (CMS, 2014), "Among hospitals with the lowest proportions of Medicaid patients, the median hospital-wide RSRR (risk-standardized readmission rate) was 0.5 percentage points lower than among hospitals with the highest proportions."

[3] TX Higher Ed. Coordinating Board's April 2012 report outlined 1.1:1 goal by emphasizing the need for an increase in the number of first-year residency programs, alluding to the reality when medical school graduates leave the state, the state's investment in medical education will leave the state.

[4] Texas is better at retaining its medical school graduates while Florida is better at retaining its resident physicians Data acquired from the AAMC 2013 State Physician Data Book.

Grant Programs	• Five new grant programs addressing GME slots were appropriated money in FY 14/15: o (1) Planning Grants: Ten awards of $150,000 each were awarded in Fiscal Years (FY) 2014 – 2015. o (2) Unfilled position grants and (3) New and expanded program grants. Unfilled Position Grants and New and Expanded Program Grants are jointly funded from an appropriation of $7.375 million. Statute mandates that each awarded residency position be funded at $65,000 per year, with the exception of Planning Grant-supported new positions, which must be funded at $35,000 per year. o (4) Primary Care Innovation Program: $2.1 million. o (5) Resident Physician Expansion Grants: $5 million	• Florida's Statewide Medicaid Residency Program allocates $80 million per year proportionally to hospitals based on number of residents.[5] • Sacred Heart Hospital Rural Primary Care Residency Program - $3 million. • Florida has no additional grants.
	• Family Medicine Residency Program: o Established in 1977 by the TX Legislature to increase the numbers of physicians selecting family medicine as their specialty. o Provides grants to Texas's nationally-accredited family medicine residency programs and provided funding support for 8,940 family practice residents. o Funding recommendations are made by the 12-member Family Medicine Residency Advisory Committee to the Higher Education Coordinating Board.	
Funding Model	• A residency program's director is the responsible party for: applying for grants, notifying the Coordinating Board if the program loses its accreditation, and providing the Board with reporting and auditing information. • Funding for residency programs goes to	• Florida's Statewide Medicaid Residency Program allocates $80 million per year proportionally to hospitals based on number of residents.[6] • Florida has no additional grants. • Department chairs and program directors must negotiate with hospital administration to secure

[5] In 2013, Governor Scott's Florida Families First Budget created and funded GME through the new Statewide Residency Program.
[6] In 2013, Governor Scott's Florida Families First Budget created and funded GME through the new Statewide Residency Program.

	hospitals, not to the residency programs.	resources for resident and fellow training. • Funding for residency programs goes to the hospitals, not to the residency programs.
GME Program Accountability	• There are accountability measures in place for any GME program receiving state-funded grants.	• No current accountability measures, as the federal GME funding model does not tie accountability with funding.
	Example: GME programs receiving the Family Medicine Residency Program grants must do the following: • Submit a series of reports to the Family Practice Residency Advisory Committee (FPRAC) and the Coordinating Board, including an annual financial report, inventory, an independent audit, future planning, and a roster of residents. • Funds provided through the grant are only authorized for the following: salaries, equipment, medical and office supplies, travel, resident salaries and fringe benefits (liability insurance), other operating costs, and certain fees (legal services). • Programs are prohibited from using funds on the following: capital expenditures, architect's fees, feasibility studies, rent paid to a public medical school, consultant fees, resident recruiting expenses, application fees to the accrediting body, etc.	
Certificate of Need (CON)	• Texas has no restrictions.	• Florida has restrictions for hospitals. AHCA regulates.[7]
Projected Specialty Shortages	• Two grant programs exist to increase the number of primary care physicians practicing in Texas.	• Florida's lack of variety in its grant programs creates no specific focus on any specialty shortages. • One grant program exists to increase the number of primary care physicians practicing in the Florida Panhandle.

[7] Other states similar to Florida in demographics and size (CA, PA) do not have CON and have significantly more ACGME slots.

RECOMMENDATIONS FOR FLORIDA

COORDINATION: Establish a policy requiring the Board of Governors (BOG) to coordinate with the Physician Workforce Advisory Council (PWAC) in establishing a strategic plan to ensure medical schools and residency programs are working to reach shared goals.

GME SLOTS: Establish a policy of attaining a 1.1 : 1 ratio of GME slots to medical school graduates, reaching the goal of having 110 open first year residency slots per 100 medical school graduates. This will retain and attract the number of physicians needed to serve Florida's growing population.

COMPETITIVE GRANTS: Establish competitive grants in the education budget to foster competition for funding among GME programs in Florida. Tie health outcomes to receipt of those grants and create accountability provisions to be reported to BOG & the Physician Workforce Advisory Council.

FUNDING MODEL: Grant funding should be provided to the GME program director and accountability should rest under their purview. Grant program should require annual audits and reviews, prescribe what the funding can and can't be used for, and require future planning.

SPECIALTY SHORTAGES: Focus at least part of the funding specifically on residency programs that will satisfy projected specialty shortages. Defer to research done through coordination of BOG and PWAC.