Miami-Dade County Charter Review Task Force Meeting
Wednesday, May 30, 2012
Miami-Dade County Miami Art Museum
101 West Flagler Street
9:00 a.m.

- **Chairman's Items**

- **County Attorney's Reports**
  - **Recommended Technical Amendments to Charter**

- **CRTF Issues of Study**
  - **Salaries / Outside Employment**
    - **Requested draft language – Commission Salary Increase Proposal**
    - **Requested draft language – Prohibition on Conflicting Outside Employment Proposal**
  - **Incorporation / Annexation**
  - **Governance of Jackson Memorial Hospital**
    - **Follow Up by County Attorney**
      - **Sovereign Immunity**
      - **½ Penny Surtax**
      - **Sunshine Law**
    - **Requested Information**
      - **2010 Grand Jury Report**
      - **2011 Hospital Governance Task Force Report**
    - **Information provided by SEIU 1991**
      - **Response to 2010 Grand Jury Report**
  - **Petition Process**
  - **Mayoral Vacancy**
    - **Mayor**
    - **Chairman of the Board**
    - **Clerk of the Courts**
  - **Office of the Inspector General**
  - **Commission on Ethics and Public Trust**
  - **Mayoral Veto / Collective Bargaining Impasse Disputes**
    - **GSAF letter**
    - **PBA letter**
  - **Office of Intergovernmental Affairs**

- **Other Business**
  - **Feedback received via the website and email**

County Attorney's Reports

Proposed by: CRTF
Introduced on: May 17, 2012
Action: Approved on May 17, 2012
Final Version: Listed on June 26, 2012 Charter Review Task Force Agenda Package

TECHNICAL AMENDMENTS - CAO

ARTICLE - 1
BOARD OF COUNTY COMMISSIONERS

* * *

SECTION 1.05. **FORFEITURE OF OFFICE** >>**OF COUNTY ELECTED AND APPOINTED OFFICIALS AND EMPLOYEES**<<**.**

* * *

SECTION 1.07. **VACANCIES** >>**IN THE OFFICE OF MAYOR OR COUNTY COMMISSIONER**<<.

* * *

ARTICLE - 3
ELECTIONS

SECTION 3.01. **ELECTION AND COMMENCEMENT OF TERMS OF COUNTY COMMISSIONERS** >>**AND MAYOR**<<.

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ARTICLE - 5
ADMINISTRATIVE ORGANIZATION AND PROCEDURE

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SECTION 5.08. **BOARDS.**

* * *

C. Dade County shall retain all its powers, including but not limited to that of eminent domain, in relation to the creation of a county-wide water and sewer system[[~~, for the purpose of cooperating with the Miami-Dade Water and Sewer Authority~~]].

ARTICLE - 6
MUNICIPALITIES

* * *

SECTION 6.03. **MUNICIPAL CHARTERS.**

A. Except as provided in Section [[~~5.04~~]] >>6.04<<, any municipality in the county may adopt, amend, or revoke a charter for its own government or abolish its existence in the following manner. Its governing body shall, within 120 days after adopting a resolution or after the certification of a petition of ten percent of the qualified electors of the municipality, draft or have drafted by a method determined by municipal ordinance a proposed charter amendment, revocation, or abolition which shall be submitted to the electors of the municipalities. Unless an election occurs not less than 60 nor more than 120 days after the draft is submitted, the proposal shall be submitted at a special election within that time. The governing body shall make copies of the proposal available to the electors not less than 30 days before the election. Alternative proposals may be submitted. Each proposal approved by a majority of the electors voting on such proposal shall become effective at the time fixed in the proposal.

* * *

SECTION 6.05. **CREATION OF NEW MUNICIPALITIES.**

The Board of County Commissioners and only the Board may authorize the creation of new municipalities in the unincorporated areas of the county after hearing the recommendations of the Planning Advisory Board, after a public hearing, and after an affirmative vote of a majority of the electors voting and residing within the proposed boundaries. The Board of County Commissioners shall appoint a charter commission, consisting of five electors residing within the proposed boundaries, who shall propose a charter to be submitted to the electors in the manner provided in Section [[~~5.03~~]] >>6.03<<. The new municipality shall have all the powers and rights granted to or not withheld from municipalities by this Charter and the Constitution and general laws of the State of Florida. Notwithstanding any provision of this Charter to the contrary, with regard to any municipality created after September 1, 2000, the pre-agreed conditions between the County and the prospective municipality which are included in the municipal charter can only be changed if approved by an affirmative vote of two-thirds (2/3) of the members of the Board of County Commissioners then in office, prior to a vote of qualified municipal electors.

* * *

ARTICLE - 8
INITIATIVE, REFERENDUM, AND RECALL

* * *

SECTION 8.02. **RECALL.**

Any member of the Board of County Commissioners, the Mayor, >>or<< the Property Appraiser[[~~, the Sheriff or Constable~~]] maybe removed from office by the electors of the county, district, or municipality by which he was chosen. The procedure on a recall petition shall be identical with that for an initiatory or referendary petition, except that:

* * *

Issues of Study

Proposed by: CRTF
Introduced on: May 30, 2012. No action taken.
Action: Approved on June 6, 2012
Final Version: Listed on June 26, 2012 Charter Review Task Force Agenda Package

Commission Salary Increase Proposal

Concept:

Amend Section 1.06 to provide that, effective with the commencement of the terms of County Commissioners in 2016, the County Commission salary will be increased from $6,000 dollars to the median income of Miami-Dade County, computed annually.

Text of Change:

MIAMI-DADE COUNTY HOME RULE CHARTER

ARTICLE-1[1]

BOARD OF COUNTY COMMISSIONERS

* * *

Section 1.06. SALARY .

>>Prior to November 22, 2016, e<<[[~~E~~]]ach County Commissioner shall receive a salary of $6,000>>, and beginning November 22, 2016, each County Commissioner shall receive a salary equal to the median income within the County, computed annually, per year payable monthly. >>Each County Commissioner<< [[~~and~~]] shall be entitled to be reimbursed for such reasonable and necessary expenses as may be approved by the Board.

[1]Words stricken through and/or [[double bracketed]] shall be deleted. Words underscored and/or >>double arrowed<< constitute the amendment proposed. Remaining provisions are now in effect and remain unchanged.

Proposed by: CRTF
Introduced on: May 30, 2012. No action taken.
Action: On June 6, 2012, CRTF requested changes. Approved as amended on June 20, 2012.
Final Version: Listed on June 26, 2012 Charter Review Task Force Agenda Package

Prohibition on Conflicting Outside Employment Proposal

Concept:

Add Subsection (d) to Section 1.05 to provide that County Commissioners may not take or hold office if they are employed by any entity that does business with the County or any entity or agency controlled by the County.

Text of Change:

MIAMI-DADE COUNTY HOME RULE CHARTER

ARTICLE-1[1]

BOARD OF COUNTY COMMISSIONERS

* * *

Section 1.05. FORFEITURE OF OFFICE.

A. Any member of the Board of County Commissioners who ceases to be a qualified voter of the county or removes himself from the county or the district from which he was elected, or who fails to attend meetings without good cause for a period of six months, shall immediately forfeit his office. Any Commissioner who ceases to reside in the district which he represents shall also immediately forfeit his office. >>Any County Commissioner who is employed by, consults for, or has an ownership interest in any firm doing business with the County or any department, office, agency or instrumentality of the County, shall also immediately forfeit his office.<<

B. Any elected or appointed county official who holds any other elective office, whether federal, state or municipal, shall forfeit his county position, provided that the provisions of this subsection shall not apply to any officials presently holding such other office during the remainder of the present terms.

[1]Words stricken through and/or [[double bracketed]] shall be deleted. Words underscored and/or >>double arrowed<< constitute the amendment proposed. Remaining provisions are now in effect and remain unchanged.

C. Any appointed official or employee of Dade County who qualifies as a candidate for election to any federal, state or municipal office shall immediately take a leave of absence from his or her county position until the date of the election and shall, if elected, immediately forfeit his or her county position. If the candidate is not elected, he or she shall immediately be reinstated to his or her former position.

IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT OF FLORIDA IN AND FOR THE COUNTY OF MIAMI-DADE

FINAL REPORT OF THE MIAMI-DADE COUNTY GRAND JURY

FALL TERM A.D. 2009

****

State Attorney
KATHERINE FERNANDEZ RUNDLE

Chief Assistant State Attorney
DON L. HORN

Assistant State Attorney
SUSAN LEAH DECHOVITZ

Assistant State Attorney
PAUL H. SILVERMAN

OSVALDO RIVERON	**JACYNTA R. HOUSE**
FOREPERSON	**CLERK**

FILED

August 5, 2010

Circuit Judge Presiding
GISELA CARDONNE ELY

Officers and Members of the Grand Jury

OSVALDO RIVERON
Foreperson

CYNTHIA BLANCK
Vice Foreperson

GUSTAVO GONZALEZ
Treasurer

JACYNTA R. HOUSE
Clerk

BLAS AQUINO

JUAN BOGARDUS

MARTA CALLAVA

PHILOMENE CARRENARD

ILEANA CASTILLO

RICARDO GARCIA DEL PRADO

ABNER GONZALEZ

STEVEN GONZALEZ

ROSA LEYVA

BEATRIZ MENA

CARLOS OLIVA

RAUL PARDO

JESSICA REMOND

DULYX TOMSINE

GLORIA M. VILLANUEVA

NICOLE S. WEINER

REGENIA WRIGHT

*** * * * * * ***

Clerk of the Circuit Court
HARVEY RUVIN

*** * * * * * ***

Administrative Assistant
ROSE ANNE DARE

*** * * * * * ***

Bailiff
NELIDO GIL, JR.

INDEX

DESIGNED TO FAIL:
A REDESIGN TO SUCCEED

I. INTRODUCTION

What a colossal mess! Jackson Memorial Hospital (JMH) is our sainted jewel of an institution that we all rely on (even if we do not go there). For some, Jackson is the hospital that is there for those who have nowhere else to go. For others, it is the one we rely on when there is a medical problem that is beyond the ken of the average practitioner. The one we rely on if, God forbid, we are in an accident or are the victim of some horrific violence. We rely on Jackson. We need Jackson. Yet, those who had the responsibility of running this institution, as well as those who had the duty of oversight, have been irresponsible, complacent and reckless, and blindly relied on financial misstatements.

This Grand Jury investigation was undertaken in the midst of exploding information about the dire financial state of Jackson Health System (JHS), our public, safety net hospital.[1] The initial purpose of our investigation was to determine the root causes of the near-financial collapse of the institution charged with the critical responsibility of providing high-quality health care to all. When we began, we had the idea that we were going to find a smoking gun. We thought we could then expose the problems and offer solutions. We thought that by investigating, hearing from many of the parties involved and learning from experts, that we could help our hospital. However, we discovered that the existing problems and many potential solutions have been known for years. Moreover, during those same years, JHS management, the Board of County Commissioners (BCC) and the Public Health Trust (PHT) have discussed the problems and solutions to no avail.

We found that many of the same issues have been the subject of various consultants' reports costing millions of taxpayer dollars. Again and again consultants reached similar conclusions and voiced similar warnings. It is said that a sign of insanity is to repeat the same behavior over and over, expecting a different result. So perhaps our investigation into what is going on at JHS has revealed the simple insanity of not listening and responding when the warning bells went off.

[1] "Safety net hospital," refers to a hospital or health system that provides a significant level of care to low-income, uninsured and vulnerable populations with limited access to health care.

It is critical to say at the outset that while we heard many complaints about what is wrong with the management of Jackson, we have not heard anything negative about the actual healthcare provided at Jackson. To the contrary, at Jackson anyone can receive world class, top notch, state of the art healthcare from excellent doctors, nurses and other healthcare practitioners. However, we are saddened at how reprehensible it would be to lose such a great asset due to a simple inability to properly manage and oversee the institution.

During our investigation we heard testimony about vast and widespread problems in many facets of the operation of the Jackson Health System (JHS). They include, among other things, problems in the areas of billing, reimbursements and implementation of computer systems. While we recognize the importance of understanding the problems at the hospital, we felt that the main focus of this report should deal with the future plans for moving toward a significantly improved operation. The problems listed are presented to give an understanding of the scope of the "mess." Understanding the magnitude of the problem is critical to understanding the recommendations that we make herein. The underlying thought is, with problems so vast and widespread, simply attacking each problem individually is a worthless effort. Sweeping change in all areas is what is required.

We recognize that much of this report contains harsh criticism. Our criticism is not in any way mean-spirited or personal. We sincerely hope it will be taken as intended – as a message for improvement and eventual survivability of our public hospital.

We feel it is important to admit that we are, frankly, angry and frustrated. We are also a bit stymied at how the actions of all the different entities involved combined to allow this fiscal crisis to happen. This is the root of the problem. This healthcare governance system is one that ostensibly has layers of oversight which include the management for Jackson Health System, the Public Health Trust (PHT) and the Board of County Commissioners (BCC) and county administrators. The concept of oversight for this model is that somewhere along the way, problems are caught and dealt with. For years, that was not done here. How can we protect ourselves so that our safety net hospital does not find itself yet again on the brink of collapse? This is the question we seek to answer.

Our findings in a nutshell are as follows:

- Jackson Health System Management, despite some valiant efforts, failed to properly manage JHS;

- The Public Health Trust, the body with the responsibility for the operation, governance and maintenance of Trust facilities, despite some valiant efforts, failed to properly oversee JHS;

- The Board of County Commissioners and County Administrators failed to properly oversee the Public Health Trust.

- While representatives of each of the above entities failed to do their job, the ultimate culprit here is the governance system itself; and

- The governance system must be changed.

II. THE CURRENT GOVERNANCE SYSTEM

Jackson Memorial Hospital (JMH) and the Jackson Health System (JHS) are run by the Public Health Trust (PHT), which operates subject to the oversight of the Board of County Commissioners (BCC). The PHT is defined as a government body comprised of 17 voting members charged with responsibility for the operation, governance and maintenance of the Trust facilities that comprise JHS. It is apparent that the BCC has almost complete and absolute control over the membership of the PHT. In fact, of the 17 voting members of the PHT, 16 are either appointed by the BCC or are sitting county commissioners.[2] There are clear conflicts between these two entities. On its website, the PHT refers to itself as an independent government body. However, Miami-Dade County Ordinance Chapter 25A, the actual ordinance creating and setting out the rules for the PHT, does not recognize it as such. No matter the entity description, the objective truth is that the BCC retains certain **significant** controls over the PHT.

In accordance with Chapter 25A of the Miami-Dade Municipal Code, the BCC, among other powers:

- Has approval rights over the budget presented by the PHT;
- Has approval rights over contracts with labor unions or other organizations representing employees;

[2] The only remaining voting member is a University of Miami trustee. See Miami-Dade Municipal Code, Chapter 25A-3 (a).

- Selects and appoints the voting trustees to the PHT from a list of nominees submitted by the Nominating Council;[3]
- Has the power to remove a trustee for cause;
- Has approval rights over the bylaws, rules and regulations for the PHT Board's governance and for the operation, governance and maintenance of designated facilities;
- Has approval rights over any changes made in the contractual relationship between the Trust and the University of Miami,[4] and
- Has approval rights over any purchase, sale or mortgage on any real property (as the County owns title to the real property.)

The above listing reveals that the BCC has significant power over the PHT. From our view, inherent within these powers and controls, is the ability (and responsibility) to step in and act if the BCC perceives that the PHT is not handling matters effectively or responsively. Stepping in when necessary is also part of the BCC's oversight responsibility. The question then becomes, has the BCC done that and if so, was it done adequately? In several instances we have determined that the BCC did not act prudently. As detailed later in this report, on several occasions they failed to act at all. On other occasions they inserted themselves and their will over that of the PHT, to the detriment of the financial stability of Jackson Memorial Hospital. The problems and tensions that exist between these two Boards are not new.

A. A Change In Relationship

In February 2002, the then mayor, in connection with a Miami-Dade County sponsored healthcare initiative, recruited Rand Health, a nationally recognized nonprofit institution specializing in research and analysis to improve policy and decision making reference healthcare organizations and financing. Rand Health wrote three detailed reports regarding the delivery of healthcare by JMH. The second of these reports was published in 2003.[5] It contained some

[3] The Nominating Council, as described in Miami-Dade Municipal Code, Chapter 25A-3(d), shall be comprised of the following five (5) voting members: the Chairperson of the Commission committee of jurisdiction for the Public Health Trust, or a Commissioner of that committee designated by the committee Chairperson; the Chairperson of the Public Health Trust; the Chairperson of the Board of County Commissioners or a Commissioner designated by the Chairperson; the Mayor or a Commissioner designated by the Mayor; and the Chairperson of the Miami-Dade Legislative Delegation or another member of the delegation appointed by Chairperson of the Miami-Dade Legislative Delegation.

[4] The University of Miami Leonard M. Miller School of Medicine utilizes Jackson Memorial Hospital as its primary teaching hospital.

[5] *Governance for Whom and for What / Principles to Guide Health Policy in Miami-Dade County*, Rand Health, 2003, Catherine A. Jackson, Kathryn Pitkin Derose, Amanda Beatty.

historical information about the creation of the PHT and how relationships between the PHT and the BCC changed over the years.

The following quotation from that report provides some enlightening history:

> When the PHT was first created by the Miami-Dade Board of County Commissioners (BCC) in 1973, there was a transparent reporting mechanism that provided the county with important oversight into how public funds were spent. Hospital management submitted detailed billing statements to county management for all indigent-care patients treated at JMH. While the county often did not reimburse the hospital fully for the care provided, there was clear accounting for indigent care provided and the public dollars used to pay for that care.
>
> Funding for the PHT changed in 1991, when the county (voters) passed a special half-penny surtax to provide funds to support JMH. These funds were earmarked "for the operation, maintenance and administration of Jackson Memorial Hospital to improve health care services." The infusion of funds financially stabilized the institution, but it broke the clear accountability and reporting mechanism, since the surtax revenues were treated like a block grant.[6] The surtax funds also provided an opportunity for the BCC to move other health-related programs into the PHT budget, giving the PHT significant oversight of health care for the entire county.[7]

While the actual governance of JHS was not changed at the time of the passage of the half-penny surtax, the reality was a change to the relationship between the BCC and the PHT. The PHT no longer accounted for itself in the way that it had before. The BCC no longer required the same detailed reporting. The result was the BCC at that time reduced its role of oversight. Some might argue it abdicated its accountability. Perhaps that was the inception of the finger-pointing problems that we see today.

The 2003 report further provided:

> Under its current governance structure, the PHT reports to the BCC. But reviews of BCC and PHT minutes suggest long-standing communication and reporting problems between the two bodies. Indeed, members of the BCC have commented that they did not feel the PHT was sufficiently accountable to them.[8]

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[6] A block grant is a large sum of money granted by the county government to an entity with only general provisions as to the way it is to be spent.

[7] Governance for Whom and for What / Principles to Guide Health Policy in Miami-Dade County," Rand Health, 2003, Catherine A. Jackson, Kathryn Pitkin Derose, Amanda Beatty, p. ix.

[8] Ibid, p. 44.

B. Prior Recognition of the Need to Change the System of Governance

Five years after the 2003 release of the second Rand Report, JHS commissioned The National Association of Public Hospitals and Health Systems (NAPH) to conduct a study of governance and legal structure options for JHS. The point of this study was to figure out what options were available to JHS to both meet its mandate of providing high-quality health care, at the same time working its way out of the financial hole in which it repeatedly found itself. The cost of this study was approximately $100,000.

The 2008 NAPH report pointed out many of the problems then facing JHS, and specifically addressed the governance issues:

> As a hospital system governed by the Miami-Dade County Public Health Trust ("PHT"), an agency of the County, the challenges facing JHS are similar to those of many other safety net hospitals. JHS operates as the County's primary safety net system and has come under increasing financial pressure in recent years, due in large part to the County's increasing indigent population, new service mandates imposed by the County, and stagnant public support. PHT, which governs and administers JHS, is also subject to significant County oversight. This oversight limits PHT's autonomy in developing operating and capital budgets and making decisions that affect JHS's organized workforce (including negotiating collective bargaining agreements with labor unions). It also constrains PHT's flexibility in structuring its affiliation with the University of Miami ("UM").
>
> Many of JHS's peer hospital systems have restructured to enable their governing bodies to confront and resolve similar challenges. Elements of these restructurings are available for reforming PHT's corporate and governance structure. Depending upon PHT's objectives (as well as any political obstacles or other influences likely to affect reform efforts), restructuring may occur contractually or through changes to governing law. As such, this report offers recommendations available through three general approaches:
>
> (1) Reforms PHT could achieve through negotiating agreements with the County's Board of County Commissioners (the "Commission");
>
> (2) Reforms PHT could achieve through changes to County law; and
>
> (3) Reforms PHT could achieve only through changes to State law.
>
> Of course, any such undertaking will require a large degree of support from the community, local government, and potentially state government, so building consensus for reform will be a critical step on the path to restructuring.[9]

[9] Report for Jackson Health System, "Recommendations Regarding Structure and Governance, Prepared by the National Association of Public Hospitals & Health Systems, January 13, 2008, p. 1.

The Executive Summary of the NAPH study has a section entitled *Key Findings and Recommendations Regarding Structure and Governance*.[10] Many of the NAPH findings included in that Executive Summary mirror some of the same issues being discussed in this present crisis. Some of the report's Key Findings include the following:

- The Miami-Dade County Board of County Commissioners (the Commission) exercises its authority over PHT in a manner that drastically limits PHT's ability to plan strategically for the short, medium or long term.
- PHT lacks adequate and stable financial support for the Jackson Health System's (JHS) core purposes, including indigent care, and other County-imposed mandates.
- PHT lacks control over its personnel system because all personnel policies and labor contracts must be approved by the Commission.

These findings clearly set out the perception and perhaps the reality of the PHT's lack of autonomy and therefore its lack of ability to control its destiny. We highlight a few of the *Key Findings and Recommendations* above solely to demonstrate that these same issues were presented to our elected officials as early as 2003, and again in 2008. The NAPH findings include recommendations for change, including a change in the governance system to grant the PHT the ability to control its financial destiny. Had these very same concepts and suggestions been considered then and appropriate action taken, perhaps we could have avoided the desperate straits in which we currently find ourselves. Unfortunately, we still have the same dysfunctional system in place despite the earlier warnings and suggested alternatives.

To highlight the problem with the present system of governance, we identify three notable examples of JHS management and the PHT making valiant efforts to forestall what became the inevitable financial fate of JHS. The examples include the attempt to get the half-penny surtax raised to a full penny, the attempt to change the system of governance and an attempt to lower JMH's labor costs. All of these efforts were stymied by actions or inaction of the BCC and county administrators.

C. The PHT's Labor Saving Costs Rejected by the BCC

When it comes to the finances of hospitals, we were told over and over that the secret to a successful hospital is twofold: having a great Chief Financial Officer (CFO) and keeping down

[10] "Overview of 'Report for Jackson Health System: Key Findings and Recommendations Regarding Structure and Governance' "

the cost of labor. Labor unions are a powerful force in the world of the BCC. How can the PHT control its financial destiny when it cannot control its labor costs?

Much has been said, publicly as well as during testimony at the Grand Jury, about labor costs having an enormous impact on the financial viability of JHS. The hue and cry to reduce the cost of labor has been announced often and with fervor. We learned that successful hospital systems running at a profit have labor costs of approximately 40-41%. We have also heard that public safety net hospitals can survive and run with labor costs as high as 50%. Our review of JMH's financial statements for the last 6 years revealed that JHS's labor costs are between 54-56% of its total operating expenses.[11] This is unacceptable as a sustainable business model.

While we find that total labor costs must be brought in line with similarly situated hospital systems, we acknowledge that organized labor officially asked the Grand Jury to look at the PHT and JHS. Additionally, we commend organized labor for their willingness to work with JHS and the PHT in trying to reach reasonable compromises that will be beneficial to all parties.

In 2004, the PHT learned of a predicted $84 million deficit. In response, the PHT hired Deloitte, a management and consulting firm. Dubbed "Project Recreate," Deloitte's job was to figure out how to get JHS out of an $84 million deficit and into the world of profit. Further, they were to figure out what was wrong, develop ways to improve and save money and create ways for JHS to actually make more money. Over a period of approximately 2-3 years, Deloitte saturated JHS with a team of people and we were told produced approximately 200 binders containing materials with suggested changes that, if implemented, could have saved JHS somewhere in the neighborhood of $200 million. The price tag for the work performed by Deloitte was approximately $80 million.

We heard that in the time period that the Deloitte-recommended $200 million savings plan was being implemented, management recognized that JHS's labor costs were too high and needed to be reduced. JHS management therefore recommended to the PHT a small increase in wages, instead of the larger one requested by the union. The PHT approved the smaller amount. As previously stated, the BCC has approval rights over the PHT's budget and the labor union contracts. When the PHT presented its proposed budget to the County for approval, the BCC

[11] See Note "b" of Exhibit 1, attached hereto.

overruled the PHT's decision and increased the wages to the larger amount. We were specifically told that this action of the BCC was in deference to the power of the unions.

The BCC was told at that time that despite all the anticipated savings based on the Deloitte recommendations, these savings would not be enough if the BCC implemented the larger wage increase. The BCC was told that with the smaller wage increase, JHS could **possibly** operate in the black. If the PHT's proposal were approved, there would be no threat to the County's safety net hospital going under. Yet, in the face of a guaranteed negative financial impact to the hospital, politics won. The survival of the politicians trumped the survivability of our safety net hospital. A gigantic warning was not only ignored, but recklessly dismissed in favor of political safety. The BCC took a course of action that was destined to make a bad situation worse. This has had the unfortunate consequence of tempering the PHT when negotiating with labor and the concomitant result of increasing the amount of the deficit. Accordingly,

We recommend that the BCC immediately fully delegate to the PHT the County's authority to approve the PHT personnel policies, and eliminate Commission authority to participate in the PHT's labor negotiations and eliminate the County's approval right over later contracts.

D. The PHT's Proposal for a Change in Governance and a New Revenue Stream

We note that in September of 2009, the PHT voted to adopt one of the recommendations from the 2008 NAPH report. Specifically, they formally voted to ask the BCC to put on the 2010 ballot a referendum asking voters to approve a different governance system for JHS that would give it greater autonomy. The PHT discussed the proposal with the Mayor's office and County officials. They rejected the PHT's proposal.

At about the same time, the PHT also requested that the BCC adopt one of its other recommendations which would ensure a new dedicated revenue stream. The PHT's proposal was for the county to ask voters to approve an additional half-penny surtax. If passed by the voters, the additional half-penny surtax could generate annual revenues in excess of $150 million for JHS. The County denied this proposal also. We were curious as to why both of these suggestions were shot down by the County, so we decided to ask.

We were told of behind-the-scenes conversations in which the changing of the governance option was requested, discussed and rejected. We also heard about other behind-the-

scene conversations with County officials in which the additional half-penny surtax was requested, discussed and rejected. In both instances, the advice by County officials was there was no political traction for either idea. We understand this to mean that there was no way either proposal would get passed due to the anathema for additional taxes. The PHT was also told by County officials to get its own financial house in order before it asked for anything like these proposals. Under normal circumstances, those would be both reasonable and cogent directives. However, how was the PHT supposed to achieve the goal of getting its financial house in order when the BCC not only rejects the PHT's cost-cutting measures, but makes decisions that actually result in higher costs to operate the hospital?

At the time these proposals were presented to the County, the recommendations from Deloitte were in the process of being instituted. The $200 million of savings were ostensibly on their way. The PHT was losing money and actively working on getting its house in order. Despite this, the BCC would not allow the PHT to control its labor costs and the PHT could not get access to an additional revenue stream (the additional half-penny surtax). The PHT told the BCC that it was not able to survive financially with the higher labor costs. The PHT was denied the savings and then denied the additional revenue. This was an impossible situation.

What did the PHT do after being told not to ask for an additional revenue stream until it got its house in order? Instead of doing everything within its power to make sure the $200 million saving plan was in fact implemented, they let the goal of "getting their house in order" just slip away.

After spending 2-3 years on the consulting job, Deloitte finally completed its work on "Project Recreate." Following completion Deloitte stayed on for an implementation phase, a major focus of which was training. Yet, as soon as Deloitte left, we were told that things at JMH reverted back to "business as usual." Employees and middle management fell back to their old ways. Many witnesses referred to this as the longstanding "culture at Jackson." However, we ask ourselves where was the resolve, the discipline to enforce new behavior, new methods and new ways of assuring financial sustainability? Management failed and then so did the PHT. It all fell apart, and "Project Recreate" became an utter failure.

The PHT failed to control its management team to ensure the recommendations from Deloitte were implemented. Thus, the PHT not only failed to achieve the $200 million in

savings, it also managed to squander the $80 million spent to learn how to save the $200 million. Deloitte left and the $200 million and the $80 million went up in a puff of smoke.

We recommend that the Deloitte reports be carefully reviewed and taken into consideration when engaged in the improvement of operations for JHS.

This utterly frustrating situation brilliantly makes the case for why we need one truly autonomous governing body for our hospital system. Give one body the power to get the job done. Then if they fail, responsibility is clear and consequences will fall into place. In this situation, with this two-headed monster of a system, how do we properly assess blame so that we recognize the solution? Everyone here was at fault. Motivations were not aligned. Disaster was inevitable.

The two potential solutions discussed in 2008-2009, the additional half-penny surtax and an alternate governance system, were shot down by the County. Even so, we ask whether the PHT was aggressive enough in pursuit of this. Where was the effort by the PHT, first to get the public behind this idea and then to utilize that momentum to go to the BCC, and get this done? Why did they not hold town meetings to get the public directly involved in the conversation? Where was the will of the PHT to get these proposals approved?

This brings us to the future. How will JHS survive? We believe that the path to survival requires a change in the governance model for JHS. Without that level of change, we are asking for this financial disaster to repeat itself, over and over again. As we said, repeating the insanity.

III. THE CURRENT SYSTEM OF GOVERNANCE MUST CHANGE

The current governance system for Jackson has been described as an unwieldy two-headed monster. It has also been described as "schizophrenic." The BCC refers to the PHT as autonomous, while in reality, it is not.[12] The truth is that because it is not truly autonomous, and because the BCC retains certain critical controls, the PHT does not act as aggressively as it could.

This "schizophrenic" system has allowed each entity, the BCC and the PHT, to point fingers at each other. Each blames the other for this crisis. The PHT says we the Trustees have

[12] The BCC maintains some significant powers over the operation of the PHT. Some of them are listed under Section II of this report, pp. 3-4.

done our best, but ultimately, we are not in control of the financial aspect of this hospital. If we are not in control of the entire financial picture, how can we be blamed for the financial crisis? The PHT also points out that the Trustees have asked for alternative and greater sources of funding. All of these have been rejected by the BCC. They ask, "How can we be responsible for this crisis when our requests have fallen on deaf ears?" On the other hand, the PHT is not entirely blameless. The Trustees failed in their duty of oversight over JHS management. As revealed later in this report, the PHT failed to recognize that a financial disaster was on the way even though the picture was being painted every month in JHS' monthly financial statements. Thus, the financial crisis is ultimately the fault of the PHT **and** the BCC **and** its county administrators.

One might argue, based on the above, that it would be appropriate to return JHS to the County as a county department. We believe that would be, to say the least, inadvisable.

Before the enactment of the current county ordinance creating the Public Health Trust, there was a separate county department that was responsible for running JHS. In the early seventies, there was a serious controversy about the county having the responsibility of running JHS as just another county department. The specific problem at that time was the continuing certification of JHS as a hospital. We were repeatedly told that the business of running a hospital requires very specific expertise. In 1973, in response to that crisis, the county enacted the ordinance that created the PHT. The county then recognized the folly of attempting to run the operation of something as large and specialized as the county's safety net hospital.[13]

While it certainly is possible to return to that model, we believe that to do so would be folly indeed. One of the messages that we have heard over and over amidst all the testimony is the hugely complicated and specialized nature of running a safety net hospital. County business is vast and complicated enough as it is. If JHS were returned as a full-fledged county department, it would be an overwhelming burden on top of all of the other existing departments. To put this in context, the County has approximately 28,000 employees. Returning JHS to the status of a county department would add 12,000 employees. Further, JHS's budget is equal to more than 25% of the direct operating budget of Miami-Dade County. To put JHS back in the

[13] Some may argue that JHS is no different than the Seaport or the Airport. We learned that those entities are designated by the County as "Enterprise Funds" and are self-supporting. Although JHS is designated as an Enterprise Fund, it has the responsibility of charity care and by its very nature and is not self-supporting.

mix of county departments would not only be irresponsible as far as running JHS, it would also take away time and attention that must be devoted to other aspects of county responsibility. Therefore, we do not suggest that JHS return to its former status as another county department.

During our investigation, the County enacted a "management watch" and then sent four county executives to oversee JHS. While we applaud the County for finally taking some definitive leadership, we hope this is merely an emergency stopgap measure that will be undone at the moment a new governance system is employed. It is apparent from the foregoing that whatever governance system is chosen for JHS, it must be one where the lines of authority are clear. There must be clear accountability and responsibility. Let one body have it all: the glory and the blame, when things go right and when things go wrong. The BCC has substantially curtailed the PHT's autonomy by maintaining its veto power over the PHT's budget and having the ability to substitute its judgment for that of the PHT Board and management.

We recommend that the BCC give greater budgetary autonomy to the PHT so that the PHT can gain enhanced control over developing and implementing the PHT's short, medium, and long-term financial strategy.

As the PHT is not a county department, we recommend that the BCC exempt the PHT from the review process generally applicable to County departments, and that it no longer require advance approval of the PHT budgets except with regard to the use of County support, financial and otherwise.

IV. THE UNHEEDED WARNINGS

Partly as a result of the problems discussed above, JMH's financial condition continued to deteriorate. In connection therewith, on February 2, 2010, an ostensibly shocking announcement was made. JMH reported a deficit of $203.8 million. An earlier announcement had referred to a deficit of **only** $46.8 million. However, by the time the dust settled, and the final numbers were out, the PHT acknowledged that the deficit was in fact $244 million. **We** were shocked. However, our investigation revealed that **others, had they paid attention, should not have been surprised** in the slightest that JHS was in very grave financial trouble.

A. "The Perfect Storm"

We heard many witnesses explain that JHS's current predicament was based on the "perfect storm." The "perfect storm" was described as a combination of the bad economy, the consequent reduction in local tax revenues, an increase in charity services and an increase in

undocumented persons requiring care at JMH. Later, officials at JMH would discover that they made some erroneous valuations and estimates. When the financial statement was adjusted for these errors, the amount of the deficit skyrocketed.[14] We were told each of these factors came together at the same time thereby creating the perfect storm. The financial crisis was portrayed as unexpected and unpredictable. We resoundingly disagree with that conclusion.

B. The Warning of the Approaching Financial Storm

While there are other examples of warnings that a fiscal crisis would inevitably befall JHS, the clearest warning of all was delivered to a joint meeting of the PHT and the BCC on June 24, 2008. At that time, the PHT and the BCC heard a presentation from JHS management, during which they were told in no uncertain terms that the financial future for JHS was dire indeed.

The PHT and the BCC were told that public hospitals throughout the nation were in crisis due to an increase in the uninsured population, the attendant increase in charity care and the decline in reimbursements by Medicare and Medicaid. Moreover, they were told that the combined existence of these conditions created a financially unsustainable model for a public, safety net hospital. Finally, the PHT and BCC were told that beginning in 2008 continuing through 2011 (when the projected time line would end), charity care costs provided by JHS would exceed the tax revenues received by JHS. The presentation included the following predicted timeline:

a. FY 2009-2010 – Uncertainty about achieving a balanced budget.
b. FY 2010-2011 - Costs would exceed revenues.
c. FY 2011-2012 - Cash on hand would be depleted and JHS would be unable to make its payroll.

After receiving this information, both the PHT and the BCC were on notice that drastic reforms had to be implemented.

Management from JHS concluded its presentation with the question, "How Can the County Help?" A specific suggestion was implementation of an additional half penny surtax. Had an additional half-penny surtax been placed on the ballot and passed, it would have meant an additional $160-190 million per year for JHS. The BCC took no action in response to JHS's

[14] See Sections V. & VI. herein for a detailed explanation.

request. No attempt was made to place it on the ballot and let the voters decide. Furthermore, as stated earlier in this report, county officials denied a later request from PHT to increase the surtax.

We are particularly dismayed with the reactions and replies of some of the witnesses who were confronted about their actions following the June 24, 2008 presentation. One reaction from the BCC was to put the problem back on JHS management with the attitude, "this is your job, and you fix it." We do not believe this is an appropriate response from one whose duty and role is one of oversight. It is also not appropriate to just outright ignore requests made that could help fix the problem, particularly when management came forward and said we cannot do this and we need your help. In so many other ways, JHS may not have been effectively managing its operation, but here, the management was actually doing its job and trying to come up with a solution. The requests made to fix the problems were things that management did not have the power to do. How else were they to get this assistance except to come forward and ask the County?

In trying to explain why the County did not act on the PHT's request, another response to JHS Management's June 24th request was, "well, no one made a specific proposal." Yet again, this sort of after the fact response, when the predicted crisis has in fact occurred, is clearly one of "It's just not my fault." It is utter nonsense to claim this as a reason for inaction. The truth is that the problem was presented, a specific solution was sought and presented and county officials failed to act. We believe the persons offering these comments were desperately trying to deflect blame when they were caught having been warned and having done nothing. It was abundantly clear in June of 2008 that disaster was afoot. The warning bell had rung. History refutes any claim of ignorance.

The June 24th presentation also clearly made the point that this governance system model does not work. It did not work because the BCC, the entity with the responsibility of oversight and power to act did not do so. Had the PHT the power to act on these matters (and others) independently of the BCC, then perhaps the current crisis could have been avoided. Oversight is supposed to catch problems and fix them before they erupt into crisis. Obviously, that did not happen here. Going back even further we see another example of a clear warning of an approaching financial crisis.

C. An Earlier Warning of the Approaching Financial Storm

As previously noted, in 2003, Rand Health issued a report that in part, addressed governance issues and suggested recommendations for improvements to policies and decision-making regarding JHS. More importantly, that second report also included direct warnings concerning the financial sustainability of JHS:

> Throughout our examination of indigent health care in Miami-Dade County, an overriding concern has been the future fiscal viability of the PHT and the Jackson Health System.[15]

Clearly, years ago the Rand report underscored the dire nature of JHS's fiscal condition.

Accordingly, the 2003 Rand Report and the June 24, 2008 JHS Management presentation to the BCC and the PHT each contained serious warnings about JHS' impending financial catastrophe. Statements such as "JHS will be unable to make its payroll" and we have an overriding concern about JHS' "future **fiscal viability"** should have been received in the same manner a prudent patient would respond to a doctor's report of a probable finding of first stage cancer. Such a patient, based on information from the doctor, understands that, untreated, the condition **will** get increasingly worse and **will** result in "death". A prudent patient would listen to the advice and suggestions of the doctor and seek treatment to cure or slow the effects of the cancer. Here the BCC and the PHT received diagnoses from several "doctors" advising that JHS (the "patient") had a life-threatening "fiscal" illness. The "doctors" recommended several treatment modalities for the patient. The BCC` and the PHT, as "guardians" of the patient did not respond prudently or appropriately. Not surprisingly, the patient's condition continued to deteriorate and the patient is now in the Intensive Care Unit on life-support.

V. THE FINANCIAL AWAKENING

To follow the analogy above, the condition of the patient (JHS) continued to worsen. As will be shown below, JHS own financial records were replete with additional warnings about the ailing patient. JHS' fiscal illness became critical at the end of FY 08-09. Notwithstanding all the warnings and diagnoses, the February 2, 2010 announcement that JHS' deficit had grown

[15] Ibid, p. 49.

from $46.8 million to $203.8 million was said to have surprised the PHT. We can only imagine their greater surprise when, weeks later the PHT discovered that the actual deficit was $244 million. What surprised us and everyone else was how the hospital administration, or those charged with its financial oversight did not foresee an increased deficit of more than five-hundred percent (500%)!

To put that in perspective, we must make an initial observation. We compared JHS' Audited Financial Statements for the time period FY03-04 through FY07-08. Within that timeframe, JHS reported an average loss of slightly more than $5 million per year.[16] To be clear, there were some years where reportedly JHS actually made a profit.[17] However, the **combined "loss"** total for those **five fiscal years** was reportedly approximately $25.4 million.[18] The loss for the next fiscal year that followed, FY08-09, suddenly became $244 million.[19] In other words, the loss for one fiscal year (FY08-09) was almost **ten times higher** than the total losses for the preceding five fiscal years. The amount and size of that variance is incomprehensible and defies logic.

During our investigation, we heard about health care and hospital finance from Auditors, Accountants (CPAs), Chief Financial Officers (CFO), Finance Directors, Controllers, Management of Jackson Health System as well as other Hospitals and Systems, just to name a few. We learned more about Hospital Accounting, Revenue Cycles, Collectibles, Reimbursements, Contractual Allowances, Gross Patient Revenue verses Net Patient Revenue, etc., than most people ever want to learn or hear about. We heard so much that our heads began to spin. We became, and are, frustrated. We learned a great deal, and at the same time, almost nothing. Grasping the facts was like trying to hold water in your hand and having it slip through your fingers.

A. JHS's Funding

At this point we think it important to describe, in general, the source of JHS's funding and how the money is spent. The funding for JHS comes primarily from the following sources: 1) Payments for patient services which include payments directly from patients or third-party

[16] See Note "d" of Exhibit 1, attached hereto.
[17] Ibid.
[18] Ibid., Note "c".
[19] Ibid, Note "a".

payers (i.e. health insurance programs, etc.); 2) Government programs like Medicare and Medicaid, and other government programs designed to subsidize low income or financially disadvantaged persons; and 3) Miami-Dade County.

The funding from the County includes a half-penny sales surtax that is assessed on the first $5,000.00 of any single sales transaction within Miami-Dade County[20]; Maintenance of Effort (MOE) funds, which are earmarked for JHS from property taxes collected by the County; and Special Assistance Payments given, on occasion, at the discretion of the BCC.[21] Even with all of these funding sources, the PHT lacks adequate and stable financial support for Jackson Health System's core purposes, including indigent care, and the other County-imposed mandates.

JHS's major operating expenses include salaries and related costs; contractual and purchased services (i.e. consultants, outside auditors, legal expenses and food services, etc.); supplies; other operating expenses and the "unfunded mandates." The unfunded mandates are programs and services the costs of which were transferred by the BCC from its budget to the PHT several years after the passage of the half-penny sales tax. Prior to that, the County was responsible to pay for these services. The unfunded mandates include, among other things, the costs associated with providing medical services to jail inmates; Community Health of South Dade, Inc.; Air Rescue helicopters; the County's Health Department; the Office of Countywide Healthcare Planning; and several primary health care centers located in North Dade and Liberty City. Both the management of JHS and PHT have consistently and vociferously complained that these costs should never have been made the responsibility of JHS. They further point out that the costs for providing these services have contributed greatly to JHS's constant financial struggle. Based on our review of certain financial data, they may be right. The total cost to the PHT for these unfunded mandates is in excess of $100 million annually. Since the BCC had the final control to transfer these duties and responsibilities to the PHT, it can reverse this action.

We recommend that the County include in its budget a specific line item that covers the total annual costs of the unfunded mandates.

[20] The limitation of the amount subject to the tax is referred to as the "$5,000 Cap."

[21] Between fiscal years 2004-2009, the BCC gave a total of $130.4 million in Special Assistance Payments to JHS (2005= $55.2 million; 2006= $30.2 million; 2008= $45 million). Within that six-year period, the **only** years where JHS did not show a deficit were the years the County gave JHS a Special Assistance Payment.

Alternatively, we recommend that if the County opts not to pay for the unfunded mandates out of the County budget, that the County pay JHS for providing the services.

We recommend that the Commission not impose new mandates or services obligations that are not adequately funded by the County.

The amount of charity services provided by JHS has also increased over the years. Even with the statutory Maintenance of Effort (MOE) contributions and the amounts generated by the half-penny surtax, JHS continues to operate at a loss in this area.[22] The monies given by the county for these services no longer cover the PHT's indigent care costs.[23] In fact, on average, the costs for providing charity services exceed the county's payment to JHS by approximately $150 million annually.

Another option for directing additional funds to JHS to offset such losses relates to what is commonly referred to as the "$5,000 cap". As previously noted, the existing half-penny sales tax is only assessed on the first $5,000 of any single sales transaction. Eliminating the cap might not be expedient and may have unintended consequences for Miami-Dade County merchants who sell high-end merchandise. Buyers could simply drive to Broward County and make the same purchases, thereby depriving the county of these funds. However, a more palatable option could be to just **raise** the cap. Raising the cap is a simple and expedient way to generate additional funding for our safety net hospital. For instance, setting a new cap of $10,000 would have the effect of adding at least an extra $25.00 in revenue for **every** new car, boat or other luxury item sold in Miami-Dade County.[24] It seems to us that raising the cap is a fairly easy and painless way to generate additional revenue for JHS.

Therefore, we recommend that the BCC re-evaluate and adjust on an annual basis the MOE contribution to JHS.

We recommend that the BCC accept the recommendation from the PHT to place on the ballot the option for voters to decide within the next two years whether they want to impose the new half-penny surtax.

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[22] For the past two years, the MOE contribution has been approximately $178 million and the surtax averaged approximately $180 million.

[23] See Exhibit 4, attached hereto.

[24] If someone purchases a car today for $15,000 that person pays a surtax in the amount of $25.00, a tax on only $5000 of the purchase price. Raising the cap to $10,000 would result in a total surtax charge of $50.00 for the same purchase.

We recommend that the BCC remove or raise the cap on the surtax from $5,000 to at least $10,000.

B. JHS's Financial Records

We examined the prior 6 years of JHS's audited financial statements to understand more completely what caused the financial meltdown at JHS. We thought that when dealing with numbers, because there are generally accepted "accounting standards," a comparison and understanding of the numbers would be relatively simple. We were wrong. What we found was anything but straight forward.

Different people had different approaches to the same financial issue, giving different numbers and explanations when asked the same question. We found that often in reports or spreadsheets, results were prepared and then later adjusted. We question whether this was due to a change in approach, the discovery of new information, or simply to ascertain a different result. Sometimes we felt as if we were hearing the old joke about the accountant being asked, "What is the sum of 2 plus 2?", and the accountant answering, "What do you want it to be?" But this is far too serious to be comical.

We heard testimony about finances that caused us to become cynical. Furthermore, we were stunned by the lack of competence certain witnesses demonstrated during the course of their testimony about the finances of JHS. Although given the opportunity to review their financial records and materials and prepare for testimony beforehand, there were times when there was complete silence in response to our questions. At other times they admitted that they were simply unable to reply. Sadly, some of these witnesses are the very employees charged with the financial well-being of JHS. The fact that they demonstrated such a lack of knowledge, expertise and a grasp of the subject matter at hand convinces us yet again that, even more, the present system of oversight is woefully inadequate. It appears to us that persons at JHS are working in positions for which they are not qualified. Had the PHT asked these witnesses the same kinds of probing questions, as they should have as part of their duty of oversight, then the PHT should have discovered the same failings long before this Grand Jury did. As the composition of the Public Health Trust includes commissioners, the BCC is also at fault for not discovering the problem with JHS' finances. These failings highlight the absolute necessity for specific hospital finance expertise on the PHT Board. The bottom line is **we have no confidence**

in the numbers presented in the internal financial reports provided by JHS and ostensibly reviewed by the PHT, which also includes elected and county officials.

We will refer to one specific example to demonstrate why we have no confidence in JHS's internal financial statements. For convenience, and to assist in our explanation of some of the financial information the PHT received every month, we have attached hereto, as "Exhibit 2", a copy of a page from the February 2009 monthly financial packet. "Exhibit 2" is entitled ***Combining Statement of Revenues, Expenses & Changes in Fund Net Assets.*** Each monthly financial packet included individual sheets with these specific financial data compilations presented on a monthly, year-to-date or trailing six month ("trended") basis.

Each document so titled first lists "***Revenue,"***[25] which is broken out by inpatient and outpatient revenue and when combined gives us "***Gross patient service revenue.***"[26] The next heading on the document, and the one we want to focus on, is "***Deduction from revenue.***"[27]

Under this section, JHS lists specific categories and amounts that will be deducted from the gross billings for medical services (technically called ***"Gross patient service revenue"*****).** Once each of these separate amounts are deducted and totaled, that combined total amount is deducted from the gross patient service revenue and we now have the dollar amount for the ***Net patient service revenue***.[28] In other words, although in February 2009 the hospital billed a total of $252,830 worth of medical services, by the time it calculated out the discounted amounts that would be paid by third parties, such as Medicare and Medicaid **(*Contractual adjustments)***, accounted for and removed the amount of free medical services provided (***Provisions for charity care***) and deducted an amount for the accounts they did not expect to obtain payments from patients (***Provisions for doubtful accounts***) JHS should then have the net amount of revenue that it expected to receive (***Net patient service revenue)***.[29] However, as reflected under Note "c" of "Exhibit 2," there is another category under the "***Deduction from revenue***" section. It is titled, ***Net Patient Revenue Adjustment*** (NPR Adjustment).

[25] See Note "a" of Exhibit 2, attached hereto.
[26] Ibid, Note "b".
[27] Ibid, Note "c".
[28] Ibid, Note "e".
[29] Ibid, Note "e".

We discovered that the Net Patient Revenue Adjustment for fiscal year 2009 had the cumulative effect of increasing projected revenue by $155 million while at the same time **concealing** $155 million of deficit. The bottom line result was a skewing of the revenue figures, and a masking of one of the indicators that could have warned of the upcoming "financial train-wreck." We note that while this adjustment was included in JHS' monthly financials it was eliminated by the independent auditor when the annual audited financial statement was prepared. Anyone looking at or relying on the numbers contained in JHS' monthly financial statements would have had a complete misunderstanding of the hospital's **true** financial condition. Not until April 2010, when an interim CFO was hired, was this practice ended.

We provided witnesses the opportunity, yet no one could adequately explain, nor could we find any reasonable justification or explanation for this ***Net Patient Revenue Adjustment*** (NPR Adjustment). Some witnesses said the adjustment was necessitated by a change in accounting methodology. They said when JHS was reporting revenue on a "cash basis" they used the adjustment. The same witnesses said the adjustment was discontinued when JHS switched the accounting method to an "accrual basis." This explanation is even included in the February 2009 monthly financial statement.[30] However, even for folks who do not understand the different accounting methods, one knows there is a problem when you find the ***Net Patient Revenue Adjustment*** (NPR Adjustment) was applied both before and after the changeover. That is exactly what we found. Including the ***Net Patient Revenue Adjustment*** served to portray a reduction in the ***Total deduction from revenue***,[31] thereby creating a false impression that there was a greater amount of revenue the hospital would collect (***Net patient service revenue***). Thus, instead of giving a realistic estimate, the adjustment actually created a fictitious "net income figure," one that could be adjusted by JHS financial management to be whatever they wanted it to be. We do not know which is of more concern; that such adjustment was applied without a good reason; or that such unexplained adjustment was applied and no one in JHS management, on the PHT or county management appears to have questioned it.

[30] Public Health Trust Jackson Health System Combined Financial Statements, February 28, 2009, pg. 1
[31] See Note "d" of Exhibit 2, attached hereto.

C. The New Patient Accounting System

In light of our inability to come up with "hard numbers" which all parties could agree upon, we were unable to do the in-depth analysis of JHS financials we had hoped to include in this report. We feel it is essential, however, to at least attempt to address the more than 500% increase in the deficit in FY 08-09. One explanation provided by management at JHS was that the spike in the deficit was caused in large part by a new Patient Accounting System (PAS). This new PAS was launched in late 2008. Although there were some problems with the implementation, it was a vast improvement over the prior system. The new accounting system captured additional patient charges previously missed.

Connected thereto, this new PAS was also said to be responsible, in large part, for an increase in accounts receivables (money owed to JHS for which payment had not been received). For our purposes, however, this increase in accounts receivables was a mirage, an image without any substance. These additional accounts receivables did not translate into any appreciable collectible revenue and they represented no real appreciable asset to JHS.

D. JHS's Miscalculation of Contractual Adjustments

What became clear to us is JHS management, during the course of the year, had no idea what caused the significant increase in its deficit. It appears they thought it was a combination of a poor collection rate and bad debt. Instead, and as pointed out by the auditor, a huge error was created by JHS administration when it used an inaccurate reimbursement rate in calculating its projected revenues. "Projected revenues" represent the amount of money JHS expected it would be paid for the medical services it billed. To understand how outrageous this error was, we must share some **basic** hospital billing information.

For FY 08-09, almost 70% of the JHS's patient revenue was derived from third-party contractual provider agreements (Medicare, Medicaid, and insurance companies).[32] Provider agreements dictate the maximum amount the third-party payer will reimburse the hospital for medical services. Accordingly, the amounts paid by Medicaid, Medicare, and other third-party (insurance) payers are usually significantly less than the total costs reflected in the hospital bill. For instance, with a surgical procedure that actually is billed at the full cost of $1,900.00, Blue-

[32] Financial statement and schedules with Report of Independent Certified Public Accounts years ending September 30, 2009 and 2008 - pages 45 & 46

Cross/Blue Shield may have an agreement with the hospital that it will only pay $475.00 for those services. Nevertheless, JHS' calculations may have resulted in a projected revenue amount of $1,000. This makes no sense. The amounts and percentages of reimbursement will vary from contract to contract, but **the hospital knows** the contract terms for **all** third party payers and the discounts each payer receives for medical billings. Therefore, JHS should have calculated and applied the proper rate of reimbursement. The fact that management used an inaccurate reimbursement rate that was higher than what was in their contractual agreements is inexcusable.[33] Applying an incorrect methodology caused the Net Patient Revenues to be adjusted, which then resulted in a downward adjustment of the accounts receivables of approximately $182 million. This also contributed approximately $182 million to the increased deficit.

Worse than that, we learned that the specific discounts and maximum payment amounts of all third-party payers could be programmed into the "new patient accounting (billing) system" which went into effect in late 2008. Using the above example again, if JHS's contractual agreement with Blue-Cross/Blue Shield for a $1,900 medical bill would result in a maximum payment of $475, the computer (Patient Accounting Billing System) could have been programmed to represent this amount. Then, each time a medical procedure was performed and a bill sent, the computer would specifically indicate that the total amount of money JMH should expect to receive as projected revenue on that bill was $475, there would be no guess work. The actual contract amounts would already be in the computer and JHS management could always get an exact **real** number for its projected revenues on every patient account. Instead of using the new Patient Account System to do the calculations, management decided to apply their own formula. That formula totally failed to take into consideration that JHS would not get more than $475 for the specific medical service used in our example above. More importantly, JHS definitely would not be receiving $1,000. Inexplicably, management chose not to rely on the capabilities of the new system but instead relied on historical data that was wrong and in direct conflict with contractual agreements of which the hospital was aware. Even if they had just

[33] Using the example above, JHS's inaccurate rate may have resulted in the hospital expecting that it was going to receive $1,000.00 on a $1,900 bill, when in fact, the maximum amount it could receive would only be $475.

checked their calculations and data against that of the automated billing system they would have recognized a huge discrepancy and hopefully sought to discover the nature of that discrepancy.

We must conclude that the information generated by this new billing system was either not utilized properly, not analyzed properly, or was simply misunderstood. This error is directly attributable to the failure of those involved in finance to recognize the problems, alert those in positions of authority and develop appropriate strategies to correct the problems. The warning signs were there for management to see, and the red flags were waving. The basic fact that there was a decrease of available cash on hand should have set off bells and whistles, causing an inquiry. At a minimum, this should have caused some inquiry by management. We find it very disconcerting that an issue of this magnitude was not identified properly.

E. The Warnings Were In the Monthly Financial Statements

Management should have known there was a problem because JHS issued monthly financial statements that were distributed to hospital management and members of the PHT. Every month JHS issues a document entitled Public Health Trust Jackson Health System Combined Financial Statements. Each monthly financial statement packet comprises approximately twenty-five (25) pages of all types of financial data regarding JHS. To demonstrate the exhaustive and extensive nature of the financial information included with each of these packets, we have attached hereto as "Exhibit 3," a representative copy of the type of Index included with each financial statement packet.

The index for each monthly financial statement packet is pretty much identical. Each monthly "financial statements" packet begins with a report from the Chief Financial Officer (CFO) that gives "highlights" for the month. Each monthly packet also included graphs, charts and financial data tracking revenue, expenses and changes to net assets. Some pages included in the packet listed information for that specific month.[34] Other pages listed the same data, but over a different time period, i.e., year-to-date or a "six month trended."[35]

Over time, the impending financial problems were revealed in these monthly CFO reports. Apparently County officials and the Trustees of the PHT, which includes

[34] See Note "b" of Exhibit 3, attached hereto.

[35] Ibid, Notes "a" & "c".

commissioners, did not realize what they were looking at or, if they did, they did not analyze the data properly. For Fiscal Year 2008-2009, the CFO's reports so plainly spelled out what was happening that we found it relatively easy to connect the dots. We made a chart of what we found to be key indicators of the mounting problem. Most of the numbers in our chart came directly from the CFO's report. All someone needed to do was look.[36]

In addition to the "numbers," the "narratives" contained in the financial reports also revealed that a financial problem was brewing. For FY 08-09, the monthly CFO reports reflected the following warning signs:

- Monthly increases in the amount of money owed to the hospital (net accounts receivables) and monthly decreases in the money coming in to the hospital (cash & investments);
- Decreases in the amount of JHS' cash on-hand caused JHS to slow the pace and amount of payments it was making to its vendors. This created an increase in the Accounts Payable (the money the hospital owed to others);
- Decreases in "cash & investments. (An advancement of funds from the County to JHS avoided what would have otherwise been a decrease of $30.8 million in "cash & investments.")
- JHS' policy was to try to keep enough "cash on hand" for 35 days of operation. The available cash on-hand dropped to 24.0 days, 11.0 days below the target.

Anyone reviewing the monthly financial reports, reading the language from the CFO's monthly highlights above or tracking the numbers contained in the reports should have realized there was a serious problem. The cash on hand was getting dangerously low, and though the projected amount of money owed to the hospital was going up, the amount of money being paid to the hospital was not. The failure of the PHT to note this trend and address it in a timely manner may speak to a need to change the eligibility requirements for those serving on the Public Health Trust.

F. More Stringent Eligibility Requirements Needed for PHT Members

Presently, the eligibility requirements for one wishing to serve on the PHT are the applicant must: 1) be a U.S. Citizen; 2) be a Miami-Dade County resident (although the BCC can waive this requirement), and 3) be of an outstanding reputation of integrity, responsibility and

[36] See Exhibit 1 attached hereto.

commitment to serving the community.[37] There is no minimal educational requirement, nor is there a requirement that one serving on the PHT have any expertise or background in finance, business or management. In fact, no particular expertise is required for any of the positions on the PHT. Nevertheless, the PHT must be sufficiently specialized to "get the job done." The PHT is currently made up of volunteers who are "of an outstanding reputation of integrity, responsibility, and commitment to serving the community."[38] We want to express our gratitude on behalf of our community to those who have served in this thankless job, despite all the described frustrations for their collective years of selfless service. At the same time however, as we recommend a complete shift in the PHT it must necessitate a change in membership. We think the failure to have more stringent eligibility requirements in the ordinance is a serious shortcoming, and one that may have contributed to the PHT's failure to catch this problem in time. In that regard:

We recommend that the BCC amend the county ordinance to require that a majority of the Trustees have experience or a background in finance, accounting, business, management or labor.

We further recommend that the BCC amend the county ordinance to require that some of the members of the PHT have backgrounds specifically in hospital finance, hospital management or experience with running a hospital.

On a related note, the county ordinance also determines the composition of the Nominating Council for the PHT. The Nominating Council conducts interviews of the applicants and makes recommendations to the BCC of persons the Council believes are qualified for appointment to the PHT. The Commissioners themselves make up the majority of the members on the Nominating Council. According to the NAPH Report, the BCC at times has ignored the Nominating Council's slate of candidates entirely.[39] The Commission's dominance on the PHT's Nominating Council creates at least the impression that all the PHT Board members are hand-picked by the Commission. Therefore, we adopt herein two recommendations from the NAPH Report.

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[37] Miami-Dade Municipal Code, Chapter 25A-3 (b)

[38] Id.

[39] "Overview of 'Report for Jackson Health System: Key Findings and Recommendations Regarding Structure and Governance'," p. 3.

We recommend that the PHT obtain a commitment from the Commission not to appoint to the Board of Trustees anyone not on the slate of candidates presented by the Nominating Council.

We recommend that the BCC increase the autonomy of the PHT by expanding the PHT representation on the Nominating Council.

Alternatively, we recommend that the BCC grant to the PHT total authority to select and appoint members to the PHT.

G. An Immediately Available Golden Opportunity

As of the issuance of this report there are five vacancies coming up on the Board of the Public Health Trust. This is a golden opportunity for the nominating commission and ultimately the BCC to take an enormous stride toward ameliorating the problems at JHS. We recognize that the existing ordinance makes no mention of the criteria mentioned in the recommendations set forth above. However, we believe it would be a simple matter for the BCC to inform the Nominating Commission that the Commissioners would like for the PHT to specifically screen applicants or seek applicants who meet the more stringent eligibility requirements above. This Grand Jury believes this would be a huge step forward to improving the abilities, knowledge and capabilities of the PHT as a whole. Therefore,

We recommend and, in fact, we implore, the PHT and the BCC to work together and utilize this opportunity to enhance the talents and capabilities of the entire PHT by nominating and appointing (respectively) new PHT members with the backgrounds and experience levels identified in the aforementioned recommendations. If there is truly a desire to change and improve JHS, this is an immediate way to do it.

VI. THE AUDIT REPORTS

At the close of each fiscal year, a team of independent outside auditors conducts an examination of the finances of JHS. Their responsibility is to tell JHS how it performed financially over a defined period of time based on certain audit (testing) procedures.[40] In addition to an audited statement, the auditor produces a report titled "Audit Results." Within this report is a "Management Letter," and other assorted documents as part of the overall evaluation of the financial statements produced by JHS's financial management team. Not surprisingly, time and again, and in various ways throughout the various documents generated, the

[40] These nationally accepted testing procedures are designed so that anyone reviewing financial statements is able to obtain reasonable assurance about whether the financial statements are free from material misstatements.

independent outside auditors were critical of the performance of the JHS financial team and the internal practices it followed.

In the 2009 Audit Results, the auditors found a "certain deficiency" that they considered a "material weakness" in internal control, which affected the JHS financial statements. Internal control, in this context, is the process designed to ensure the accuracy and reliability of financial reporting in compliance with both generally accepted accounting standards and applicable laws and regulations. The audit cited the overvaluation of the amount of money owed to JHS as a consequence of this "material weakness." In other words, this criticism specifically relates to JHS' "projected revenues" calculation error referred to in Section V. D. above.

JHS management's error in calculating its projected revenues had such a gigantic impact in creating a false financial picture for the hospital that this error was cited in several sections of the "*2009 Audit Results*". In fact, the auditors challenged the reasonableness of the estimation techniques and the assumptions JHS management used in calculating its projected revenues.[41] Further, the auditors found that during Fiscal Year 2009, the JHS's patient accounts receivables (projected revenues) were **significantly overstated** in its monthly financial statements. This overstatement resulted in a "material" misstatement being presented in each of JHS' monthly financial statements.

Moreover, the auditors found that JHS management's internal controls were also deficient and constituted a material weakness."[42] The "checks and balances" (internal controls) JHS management had in place were insufficient to "allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct [material] misstatements on a timely basis."[43] Specifically, management's controls relating to the patient accounts receivable valuation process did not identify the overstatement of patient accounts receivables in a timely manner.[44] After hearing much expert financial testimony, we agree with

[41] This criticism and finding is what ultimately led to management's adjustment of the $182 million in accounts receivables, and for management to change its methodology going forward.

[42] The 2009 Audit Results, March 9, 2010, prepared for the Public Health Trust of Miami-Dade County, Florida, Appendix B, p. 2.

[43] Ibid.

[44] Ibid, p. 1.

the auditors. Management's process for formulating sensitive accounting estimates was flawed and the assumptions used in calculating estimates lacked the necessary analytical foundations. Again, this resulted in a totally misleading and unreliable picture of JHS' true financial condition.

In comparing year-over-year data from FY 07-08 to FY 08-09, the auditors noted that the "Unrestricted fund net assets"[45] declined 123%, "Working capital"[46] declined 135%, and the "Days cash on hand"[47] declined 43%. Had JHS management, the PHT and other county officials made themselves aware of these ascertainable indicators as they developed during the year, the dramatic deterioration and worsening of the financial condition of "our" public health system would not have come as a surprise.

We found that the lack of internal control outlined in the 2009 Management letter was a primary cause of the required adjustment and increase of the deficit/loss from the original $46.8 million loss (arrived at by the JHS financial management team), to the $244 million figure (arrived at with the independent auditor). It is clear to us that the JHS financial management team either had no concept of the hospital's actual financial circumstances, or chose to ignore or hide them, until the independent auditor made it impossible to continue to do so.

JHS management should have recognized the problems. The PHT as well as county officials who regularly attend the PHT meetings, should have been able to read the proverbial handwriting on the monthly reports. The PHT, as we have pointed out previously in this report, is the next layer of oversight after management. It has the duty and obligation of protecting our public hospital. The PHT's specific job is to make sure something like this does not happen. A critical point must be made again. The PHT is comprised of exemplary citizens who donate their

[45] The part of net assets of a not-for-profit organization that is neither permanently restricted nor temporally restricted by donor-imposed stipulations.

[46] Current assets minus current liabilities. Working capital measures how much in liquid assets a company has available to build its business. The number can be positive or negative, depending on how much debt the company is carrying. In general, companies that have a lot of working capital will be more successful since they can expand and improve their operations. Companies with negative working capital may lack the funds necessary for growth. Also called current assets or current capital.

[47] DAYS CASH ON HAND is calculated: Cash/([operating expense - depreciation expense]/365).

time to the very laudable cause of protecting this hospital. That is all well and good, but as discussed above, there must be a requirement that some members of the PHT have the requisite and specific financial background to fulfill the PHT's duty of financial oversight. This is yet another example of how this governance system has failed. Whatever governance system is ultimately chosen for JHS, even if it is to simply remain the same, it must include true oversight with PHT members who have backgrounds and experience in hospital finance and accounting.

VII. CONCLUSION AND RECOMMENDATIONS

The warning bells were rung. Again and again. Year after year. The warnings were, for the most part, ignored.

We have listened to many lay blame and seen many point fingers. It is the PHT's fault. It is the BCC's fault. The PHT is autonomous. The BCC holds too many strings and we can not really control our own destiny.

One conclusion is resoundingly clear. The current governance system has not worked, is not working and must change. This is not because of any individual who holds any particular position. It is because the current system is unwieldy. It is because the current system lends itself to finger pointing and blame, without a clear line of actual responsibility. And, most importantly, because it simply has not worked.

We, the Grand Jury, are not experts in the hospital arena. We are a group of 21 citizens of Miami-Dade County who are worried and frightened for the future of our hospital. We do not pretend to have sufficient expertise to select one governance system over another. If we did so, we would be correctly subject to the criticism of, "who are you to tell a hospital what to do?"

Much can be gleaned from the response to a crisis. As to the response to this crisis, we are breathing a gigantic sigh of relief. Each and every relevant party has responded in ways that are to be commended, applauded and extolled. It is obvious to us that out of crisis has come a desire to get it right. We are grateful to those who have immersed themselves in this fight for survival and thank you for your steadfast resolve as we move forward.

We have taken the time to investigate this crisis and as a result, we know just how massively complicated the problems are at JHS. We point this out to underscore that others out there who offer solutions who are not truly experts, should not do so. The way to come to the

correct system of governance for JHS is for a group of true experts to come together immediately and decide the best model for operating this safety net hospital. This group should have no outsiders, but be comprised of local people, dedicated to the county in which we live, and who have an intimate, direct and personal understanding of how to run a successful hospital. They should make this decision, from a vantage point of their dedication to us as a community and with a foundation of knowledge beyond the ken of any other.

SPECIFICALLY, WE RECOMMEND

That the County Management Watch continue, with the goal of stabilizing JHS

That each of the relevant parties continue to work together toward stabilization

That while the stabilization process continues, a group as described above be appointed to study and recommend what would be the best governance system for JHS.

That this group be comprised of long standing, exemplary members of our community who in addition have consummate skills, knowledge and expertise specifically in the areas of hospital finance, hospital management and hospital governance systems; specifically a current or former CEO of a successful local hospital or hospital system, a current or former CFO of a successful local hospital or hospital system and an academician/expert in the area of healthcare

And that a future Grand Jury, one year from now, conduct the next phase of this investigation, that is to continue the Grand Jury Watch to look at the progress that has been made to guarantee that a financially sustainable future for JHS is obtained.

LIST OF OTHER RECOMMENDATIONS

Some of the recommendations presented in the body of this Report and set forth here in summary fashion were initially included with an extensive list of recommendations from the NAPH Report. Many of those earlier recommendations go hand-in-hand with our findings. As such, we have reiterated or modified some of those prior recommendations. They can all be identified by the presence of an asterisk at the end of each specific recommendation.

1. *We recommend that the BCC fully delegate to the PHT the County's authority to approve the PHT personnel policies, and eliminate Commission authority to participate in the PHT's labor negotiations and eliminate the County's approval right over later contracts.**

2. *We recommend that the BCC give greater budget autonomy to the PHT so that the PHT can gain enhanced control over developing and implementing the PHT's short, medium, and long-term financial strategy.**

3. *We recommend that the County include in its budget a specific line item that covers the total annual costs of the unfunded mandates.*

4. *We recommend that the Commission not impose new mandates or services obligations that are not adequately funded by the County.**

5. *We recommend that the BCC re-evaluate and adjust on an annual basis the MOE contribution to JHS.*

6. *We recommend that the BCC accept the recommendation from the PHT to place on the ballot the option for voters to decide whether they want to impose the new half-penny surtax to help save our safety net hospital.*

7. *We recommend that the BCC amend the county ordinance to require that a majority of the Trustees must have experience or a background in finance, accounting, business, management or labor.*

8. *We further recommend that the BCC amend the county ordinance to require that some of the members of the PHT have backgrounds specifically in hospital finance, hospital management or experience with running a hospital.*

9. *We recommend that the PHT obtain a commitment from the Commission not to appoint to the Board of Trustees anyone not on the slate of candidates presented by the Nominating Council.**

10. *We recommend that the BCC increase the autonomy of the PHT by expanding the PHT representation on the Nominating Council.**

11. *Alternatively, we recommend that the BCC grant to the PHT total authority to select and appoint members to the PHT.**

12. *We recommend and, in fact, we implore the PHT and the BCC to work together and utilize this opportunity to enhance the talents and capabilities of the entire PHT by nominating and appointing (respectively) new PHT members with the backgrounds and experience levels identified in the aforementioned recommendations. If there is truly a desire to change and improve JHS, this is an immediate way to do it.*

ACKNOWLEDGMENTS

Nine months ago twenty-one randomly selected individuals were brought together to form the Miami-Dade Grand Jury, Fall Term 2009. These jurors, initially separated by age, ethnicity and cultural diversity, were able to unify as a group to form a motivated team. The experience resulted in a greater knowledge and lifelong respect and appreciation for our judicial system.

It was an honor to serve on the Miami-Dade County Grand Jury and we encourage our fellow citizens to participate in this important civic duty when our local government calls them to serve. We are also grateful for having the opportunity to be an influential part of the judicial process. We would like to take this opportunity to express our thanks to the following, who have all managed innumerable duties with a cheerful and friendly attitude:

- Honorable Judge Gisela Cardonne Ely, who not only stressed the importance of serving on a grand jury, but also the significance of being involved in the community.
- State Attorney Katherine Fernandez Rundle, for her advice, commitment and years of service to the Miami-Dade County community and its judicial system.
- Chief Assistant State Attorney Don Horn, for his professionalism, dedication and support. His knowledge and guidance not only educated us but made our service a truly rewarding experience. Our deepest thanks for making our job easier.
- Susan Dechovitz, Assistant State Attorney, for her professionalism and enthusiasm, dedication and support on all these months of hard work.
- Paul Silverman, Assistant State Attorney, for his wonderful work, research and enthusiasm for our investigation, making sure the Jury had all the "pieces put together."
- Rose Anne Dare, who took care of all administrative details for each and everyone of us. Her professionalism and skills made our task easier to perform.
- Nelido Gil, our Bailiff, who every day greeted us with a smile, and made our days as jurors run as smoothly as possible. His ability to keep us in good spirits was definitely appreciated by all.
- Our court reporters, for their professionalism and commitment.
- To those witnesses and experts who took their time to come before us and answered all of our questions and concerns, we also thank you.

Our task was difficult and our journey through the judicial system was at times disturbing, frustrating and surprising. It was an experience we will never forget.

It has truly been a privilege and honor to serve our community.

Respectfully submitted,

Osvaldo Riveron, Foreperson
Miami-Dade County Grand Jury
Fall Term 2009

ATTEST:

Jacynta House
Clerk

Date: August 5, 2010

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
(A) JANSYS LAZARO HERRERA and (B) JORGE MIGUEL PANTALEON	First Degree Murder Burglary With Assault or Battery Therein While Armed Robbery Using Deadly Weapon or Firearm	True Bill
(A) VENISE METAYER and (B) STEVE CARLOS ARMAND	Murder First Degree (A&B) Kidnapping With a Weapon (A&B) Burglary With Assault or Battery Therein While Armed (A) Burglary With Assault or Battery Therein While Armed (B) Grand Theft Third Degree (A&B)	True Bill
JASON TOMAS FERNANDEZ	Sexual Battery Victim Under 12 Yrs Lewd Assault on a Child Under 16/ Intercourse Lewd Assault on a Child Under 16/ Intercourse	True Bill
KENDRICK CLARENCE SILVER and ONIEL PEDLEY	First Degree Murder Robbery/Firearm Attempt Burglary/Armed/Attempt Robbery/Armed/Conspiracy Burglary/Armed/Conspiracy	True Bill
DAVID MORALES	Sexual Battery Victim Under 12 Yrs Sexual Battery Victim Under 12 Yrs	True Bill
WILLIAM HENRY BROWN, also known as "LITTLE BILL"	First Degree Murder Murder/Premeditated/Attempt/ D Weapon Firearm/Weapon/Ammunition/Posn by Convicted Felon or Delinquent	True Bill
JASON COLON and CHRISTIAN G. VILLAFANE	First Degree Murder Kidnapping With a Weapon Petit Theft ID/$100+/-$300	True Bill
ERNESTO ALFONSO and NESDY M. GARCIA	First Degree Murder Robbery Using Deadly Weapon or Firearm Robbery/Armed/Conspiracy Accessory After the Fact/Capital Offense Accessory After the Fact	True Bill
MICHELLE SPENCE-JONES	Grand Theft Second Degree	True Bill
MICHELLE SPENCE-JONES	Bribery/Offering/Accepting	True Bill
WILLIAM J. TIBE and SHAMAR OMAR EDWARDS	First Degree Murder Murder Second Degree / Felony Burglary of an Unoccupied Conveyance Grand Theft Third Degree	True Bill

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED
ALRIC CHRISTOPHER BERRY also known as "Q"	First Degree Murder Attempted Felony Murder with a Deadly Weapon or Aggravated Battery Firearm/Weapon/Ammunition Posn By Convicted Felon or Delinquent Illegal Drugs / Conspire to Traffic/Armed Illegal Drugs / Trafficking Armed	True Bill
JEORGE A. SMITH	First Degree Murder Carrying a Concealed Firearm	True Bill
(A) ERROR ALVIN LATSON and (B) LIUGANS JOSEPH WILSON	First Degree Murder (A&B) Robbery Using Deadly Weapon or Firearm (A&B) Resisting an Officer Without Violence to His/Her Person (A only) Resisting an Officer Without Violence to His/Her Person (A only) Driving While License Suspended / Knowingly (B only)	True Bill
CURTIS PERRY	First Degree Murder Firearm/Weapon/Ammunition Posn by Convicted Felon or Delinquent First Degree Murder / Conspiracy	True Bill
ANTHONY EROMOSE BANMAH	First Degree Murder First Degree Murder Robbery Using Deadly Weapon or Firearm Firearm/Weapon/Ammunition Possession By Convicted Felon or Delinquent	True Bill
JONATHON NODAL	First Degree Murder First Degree Murder	True Bill

PUBLIC HEALTH TRUST
JACKSON HEALTH SYSTEM
COMBINED FINANCIAL STATEMENTS
September 30, 2009

INDEX

Exhibit 3

Public Health Trust of Miami-Dade County, Florida
Cost of Safety Net / Charity Services
(Amount in Millions)

Description	Fiscal Year Ended September 30					
	2004	2005	2006	2007	2008	2009
	Amount	Amount	Amount	Amount	Amount	Amount
Sales Tax Revenue Act						
Charity Service Costs	$ (462,047,253)	$ (424,566,928)	$ (454,612,374)	$ (504,151,870)	$ (531,392,619)	$ (618,957,660)
Miami-Dade County Funding	$ 119,110,007	$ 123,066,005	$ 140,424,229	$ 160,707,202	$ 178,059,996	$ 177,870,000
Miami-Dade County (Special) Assistance	$ -	$ 55,200,000	$ 30,173,168	$ -	$ 45,000,449	$ -
Sales Tax Revenue	$ 161,811,758	$ 170,457,857	$ 189,699,732	$ 190,871,912	$ 187,408,133	$ 172,816,473
Gross Charity Service Revenue >	$ 280,921,765	$ 348,723,862	$ 360,297,129	$ 351,579,114	$ 410,468,578	$ 350,686,473
Unfunded Charity Service Costs >	$ (181,125,488)	$ (75,843,066)	$ (94,315,245)	$ (152,572,756)	$ (120,924,041)	$ (268,271,187)

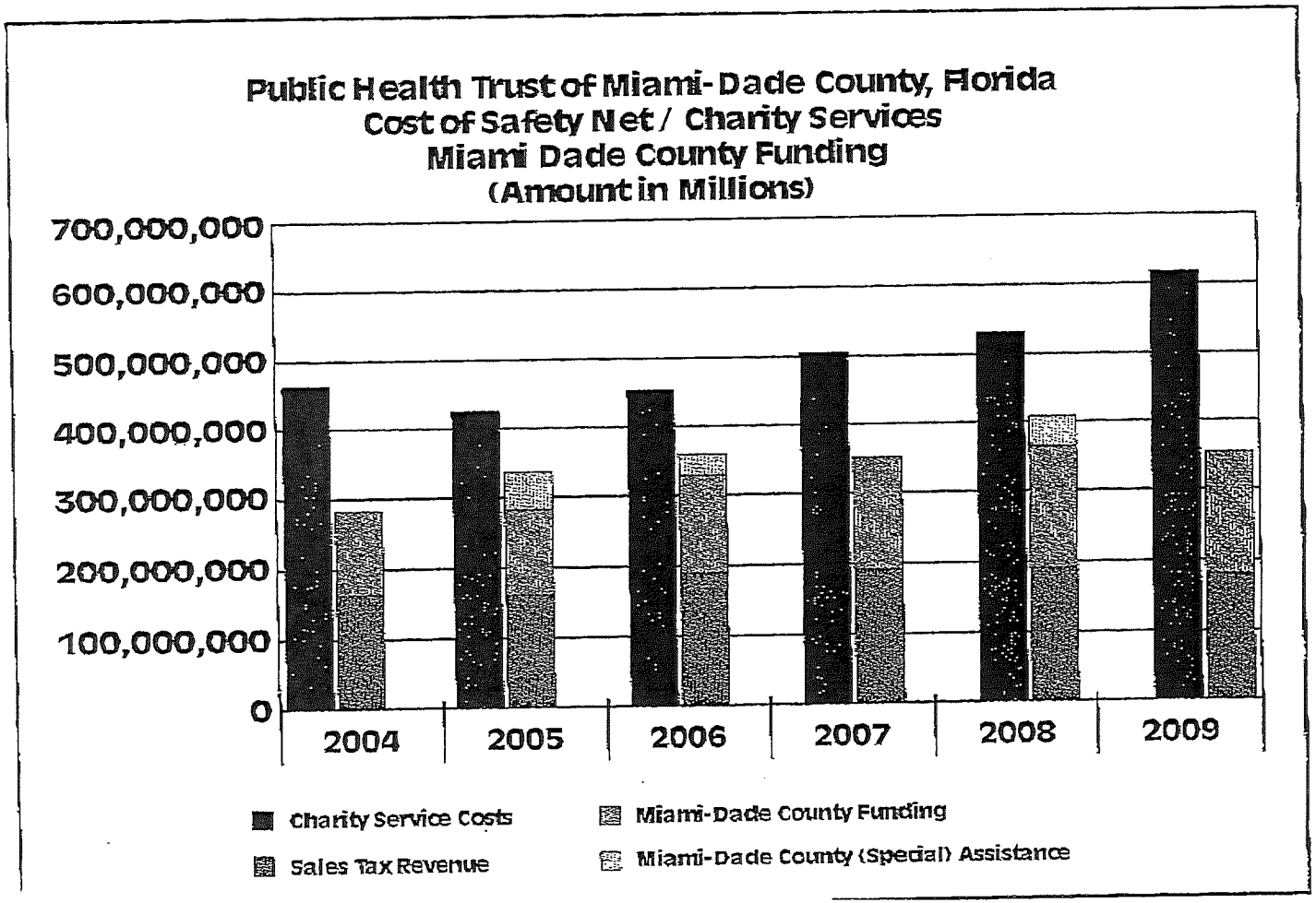

Exhibit 4

Public Health Trust of Miami-Dade County, Florida
Schedule of Revenue & Expenses
(Amount in Millions)

Description	Fiscal Year Ended September 30					
	2004	2005	2006	2007	2008	2009
Operating Revenues						
Net Patient Service Revenue	$ 820,200,800	$ 925,036,422	$ 959,786,309	$ 1,069,017,573	$ 1,187,236,154	$ 1,047,746,597
Other Revenue	$ 133,100,112	$ 133,729,491	$ 143,495,234	$ 185,325,834	$ 216,720,550	$ 176,187,863
Grants & Other	$ 25,189,350	$ 25,652,646	$ 29,197,611	$ 27,919,457	$ 31,645,037	$ 28,254,525
Total Operating Revenues >>>	$ 978,490,262	$ 1,084,418,559	$ 1,132,479,154	$ 1,282,262,864	$ 1,435,601,741	$ 1,252,188,985
Operating Expenses						
Salaries & Related Costs	$ 761,956,140	$ 782,430,457	$ 815,712,675	$ 947,680,440	$ 1,010,214,555	$ 1,015,280,009
Contractual & Purchased Services	$ 296,417,642	$ 337,068,112	$ 345,927,558	$ 424,434,009	$ 499,130,813	$ 536,824,167
Supplies	$ 205,401,779	$ 200,875,574	$ 194,266,329	$ 224,771,334	$ 240,000,320	$ 238,179,026
Other Operating Expenses	$ 40,574,259	$ 48,052,767	$ 44,954,328	$ 50,314,196	$ 48,738,744	$ 9,892,019
Public Medical Assistance Trust Fund Assessment	$ 10,434,099	$ 11,577,780	$ 11,332,396	$ 12,509,609	$ 13,356,371	$ 15,065,601
Depreciation & Amortization	$ 36,260,910	$ 37,761,646	$ 39,352,565	$ 46,861,188	$ 50,446,944	$ 55,489,187
Total Operating Expenses >>>	$ 1,351,044,829	$ 1,417,766,336	$ 1,451,545,851	$ 1,706,570,776	$ 1,861,887,747	$ 1,870,730,009
Net Operating Income/(Loss) >>>	$ (372,554,567)	$ (333,347,777)	$ (319,066,697)	$ (424,307,912)	$ (426,286,006)	$ (618,541,024)
Non-Recurring Adjustments						
Cumulative Effect of accounting changes	$ (2,735,916)	$ -	$ -	$ -	$ -	$ -
Refund of Grant	$ -	$ (6,693,306)	$ -	$ -	$ -	$ -
Total Non-Recurring Adjustments	$ (2,735,916)	$ (6,693,306)	$ -	$ -	$ -	$ -
Non-Operating Revenues						
Miami-Dade County Funding	$ 119,110,007	$ 123,066,005	$ 140,424,229	$ 160,707,202	$ 178,059,996	$ 177,870,000
Miami-Dade County (Special) Assistance	$ -	$ 55,200,000	$ 30,173,168	$ -	$ 45,000,449	$ -
Sales Tax Revenue	$ 161,811,758	$ 170,457,857	$ 189,699,732	$ 190,871,912	$ 187,408,133	$ 172,816,473
Investment Income	$ 2,511,425	$ 6,633,629	$ 20,008,856	$ 23,441,014	$ 12,391,136	$ 3,925,734
Other Income	$ 15,339,092	$ 3,781,007	$ 11,477,067	$ 30,345,939	$ 44,134,614	$ 33,292,086
Sub-Total >>>	$ 298,772,282	$ 359,138,498	$ 391,783,052	$ 405,366,067	$ 466,994,328	$ 387,904,293
Interest Expense	$ (8,640,717)	$ (8,248,105)	$ (15,451,732)	$ (15,066,945)	$ (15,029,263)	$ (13,948,100)
Total Non-Operating Revenue, Net>>>	$ 290,131,565	$ 350,890,393	$ 376,331,320	$ 390,299,122	$ 451,965,065	$ 373,956,193
Net Income/(Loss) >>>	$ (85,158,918)	$ 10,849,310	$ 57,264,623	$ (34,008,790)	$ 25,679,059	$ (244,584,831)
Labor cost as % of total operating costs	56.3975%	55.1875%	56.1961%	55.5313%	54.2575%	54.2719%

Description	Fiscal Year Ended September 30					
	2004	2005	2006	2007	2008	5 Yr Total
Net Income/(Loss) >>>	$ (85,158,918)	$ 10,849,310	$ 57,264,623	$ (34,008,790)	$ 25,679,059	$ (25,374,716)

Description	Fiscal Year Ended September 30					
	2004	2005	2006	2007	2008	5 Yr Average
Net Income/(Loss) >>>	$ (85,158,918)	$ 10,849,310	$ 57,264,623	$ (34,008,790)	$ 25,679,059	$ (5,074,943)

Public Health Trust
Jackson Health System
Combining Statement of Revenues, Expenses & Changes in Fund Net Assets
Month ended February 28, 2009
(Amounts in thousands)

	Jackson Memorial Hospital	Jackson South Community Hospital	Jackson North Medical Center	Community Medical Practices	Division of Managed Care	Primary Care Centers	Corrections Health Services	Skilled Nursing Facilities (SNF)	Jackson Medical Towers	Total	Prior Year
Revenue:											
Inpatient Revenue	$ 186,751	20,565	31,264	-	-	-	-	2,401	-	240,980	249,081
Outpatient Revenue	66,079	8,619	9,858	3,941	-	2,487	-	209	-	91,193	81,560
Gross patient service revenue	252,830	29,184	41,122	3,941	-	2,487	-	2,610	-	332,174	330,641
Deduction from revenue:											
Contractual adjustments	100,280	17,674	19,870	2,226	-	381	-	175	-	140,605	118,892
Provisions for charity care	72,553	1,007	1,958	0	-	1,089	-	798	-	77,406	86,342
Net Patient Revenue Adjustment	(27,778)	(1,044)	873	-	-	-	-	-	-	(27,949)	6,237
Provisions for doubtful accounts	28,169	3,072	7,694	-	-	27	-	10	-	38,973	23,842
Total deductions from revenue	173,224	20,708	30,396	2,226	-	1,498	-	983	-	229,035	235,313
Net patient service revenue	79,605	8,476	10,726	1,716	-	989	-	1,627	-	103,139	95,328
Division of managed care	-	-	-	-	13,246	-	-	-	-	13,246	14,240
Other operating revenue	3,371	324	47	89	-	170	-	1	422	4,423	4,386
Grants revenue	2,265	-	-	-	-	-	-	-	-	2,265	2,192
Total operating revenue	85,241	8,800	10,773	1,805	13,246	1,159	-	1,628	422	123,073	116,146
Operating Expenses											
Salaries,wages and employee benefits	62,686	5,577	5,749	-	888	2,348	1,884	2,346	35	81,513	79,581
Contractual and Purchased Services	29,598	1,177	2,411	1,706	11,560	1,349	12	333	308	48,455	39,852
Supplies	15,982	1,053	1,522	102	(2)	99	180	236	9	19,181	17,967
Depreciation and amortization	3,890	273	321	39	5	19	2	41	15	4,606	4,086
Interest	816	-	-	-	-	-	-	-	34	850	1,263
Other	3,637	213	314	-	-	2	-	-	-	4,166	4,990
Total operating expenses	116,609	8,293	10,317	1,847	12,451	3,818	2,079	2,956	401	158,771	147,739
Excess of operating revenue over (under) operating expenses	(31,368)	508	456	(42)	794	(2,659)	(2,079)	(1,328)	20	(35,698)	(31,593)
Other Revenue (Expense)											
Investment Income	272	3	1	-	8	0	-	0	1	286	1,105
Unrestricted Health Care Surtax	14,162	-	-	-	-	-	-	-	-	14,162	16,250
Miami Dade County Unrestricted funds	14,823	-	-	-	-	-	-	-	-	14,823	14,838
Other Income	1,226	-	-	-	-	-	-	7	-	1,233	1,331
Miami Dade County Special Contributions	-	-	-	-	-	-	-	-	-	-	3,750
JM Foundation	-	-	-	-	-	-	-	-	-	-	-
Miami Dade County GOB Contributions	-	-	-	-	-	-	-	-	-	-	-
Total other revenue(expenses)	30,483	3	1	-	8	0	-	8	1	30,504	37,274
Excess of revenues over (under) expenses	$ (884)	$ 511	$ 457	$ (42)	$ 803	$ (2,659)	$ (2,079)	$ (1,320)	$ 21	$ (5,194)	$ 5,681

HGT

Miami-Dade County Hospital Governance Taskforce

Chairperson
Juan C. Zapata

Vice Chairperson
Susan Leah Dechovitz

Members
Manuel P. Anton, III
Martha Baker
Michael Barron
Jose Cancela
Lee Chaykin
Edward J. Feller
Robert B. Johnson
Brian E. Keeley
M. Narendra Kini
Marisel Losa
Steven E. Marcus
Ana Mederos
Linda S. Quick
Steven D. Pinkert
Sharon Pontious
Lillian Rivera
Donna E. Shalala
Steven Sonenreich

Hospital Governance Taskforce

Final Report

May 12, 2011

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HGT

Miami-Dade County Hospital Governance Taskforce

Website:
http://www.miamidade.gov/auditor/hospital_governance.asp

Staff Contact:
S. Donna Palmer, Coordinator
Office of the Commission Auditor
(305) 375-4573
spalmer@miamidade.gov

May 12, 2011

The Honorable Joe A. Martinez, Chairman and
Members, Board of County Commissioners
Stephen P. Clark Center
111 N.W. First Street
Miami, FL 33128

Dear Chairman and Members:

It is with great satisfaction that we submit the Hospital Governance Taskforce Final Report with recommendations on alternative models for operating Jackson Health System to ensure it has the governing and financial structure necessary to fulfill its crucial mission. We all agree that Jackson Health System is a vital community resource, and its mission is in jeopardy. We urge that an aggressive timetable be set to implement the recommendations of this Taskforce and that it be done with a sense of urgency.

The Taskforce's first meeting was on March 28, 2011, and the last meeting was on May 12, 2011, at which time final recommendations and this report were approved. We are proud to complete our recommendations and final report well within the 90 days authorized by Resolution No. R-30-11.

In our deliberations, we considered and support the recently established Financial Recovery Board. As you, Chairman Martinez, noted in your May 2, 2011 memorandum, the Financial Recovery Board represents "Phase I of a recovery plan," and the Taskforce's recommendations will be considered for Phase II. We urge that the Financial Recovery Board's term be shortened, to coincide with the completion of the implementation of the new governance structure. We also urge immediate establishment and funding of an implementation committee to prepare for and become the new governing body and to ensure continuity in governance and community services.

We thank the Board of County Commissioners for this opportunity to make recommendations on such a critically important subject for the health of this community. We also extend our special thanks to Commissioner Rebeca Sosa for sponsoring the resolution creating this Taskforce. In particular, we thank our fellow Taskforce members, the Office of the Commission Auditor, the Clerk of the Board, and the County Attorney's Office for their valuable contributions to this Taskforce and this community.

c: Juan C. Zapata, Chairman and Members, Hospital Governance Taskforce
Harvey Ruvin, Clerk of Courts
Alina T. Hudak, County Manager
R. A. Cuevas, County Attorney
Charles Anderson, Commission Auditor
Christopher Agrippa, Transitional Division Chief, Clerk of the Board Division

Juan C. Zapata, Chairman
Hospital Governance Taskforce

Susan Leah Dechovitz, Vice Chairperson
Hospital Governance Taskforce
Miami-Dade State Attorney's Office

Dr. Manuel P. Anton, III, President/CEO
Mercy Hospital

Marisel Losa, MHSA, President /CEO
Health Council of South Florida

See Dissenting Opinion - MBaker
Martha Baker, RN, President
SEIU Healthcare Florida, Local 1991

Dr. Steven Marcus, President/CEO
Health Foundation of South Florida

Dr. Michael Barron
President, Medical Executive Committee of JMH

Ana Mederos, MBA, CEO
Palmetto General Hospital

Jose Cancela, Principal
Hispanic USA, Inc.

Linda S. Quick, President
South Florida Hospital & Healthcare Assoc.

Lee Chaykin, CEO
Kendall Regional Medical Center

Steven D. Pinkert, MD, JD, MBA
Pinkert & Marsh P.A.

Edward J. Feller, MD

Dr. Sharon Pontious, Representative
Florida Nurse's Association

Robert B. Johnson, Representative
National Association of Public Hospitals
& Health Systems

Lillian Rivera, RN, MSN, Ph.D.
Administrator
Miami-Dade County Health Department

Brian E. Keeley, President/CEO
Baptist Health South Florida, Inc.

Donna E. Shalala, President
University of Miami

Dr. M. Narendra Kini, President/CEO
Miami Children's Hospital

Steven D. Sonenreich, President/CEO
Mount Sinai Medical Center

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[1] Attachment from Valda Christian, Assistant County Attorney, email of Mon 4/4/2011 3:25 PM
[2] R. A. Cuevas, Jr., County Attorney, memorandum of February 25, 2010
[3] R. A. Cuevas, Jr. County Attorney, memorandum of March 9, 2011
[4] Karon M. Coleman, Assistant County Attorney, memorandum of May 6, 2011
[5] R. A. Cuevas, Jr., County Attorney, memorandum of May 5, 2011
[6] Data compiled by the Office of the Commission Auditor
[7] Data compiled by the Office of the Commission Auditor
[8] Florida Agency for Health Care Administration (AHCA) Medicaid-related Financial Data, FYE2009

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Executive Summary

This report from the Miami-Dade County Hospital Governance Taskforce (Taskforce) presents recommendations resulting from its considerations of alternative governance models available for Miami-Dade County's Jackson Health System. These recommendations represent the general consensus opinion of the Taskforce.

The Taskforce makes eighteen recommendations, including that the recommendations of the Taskforce be viewed in its entirety rather than selectively and that an aggressive timetable be set for implementing the recommendations. The Taskforce also recommends emphasis on Jackson Health System as an integrated healthcare system, rather than a hospital, and that Jackson Health System have an organization and governance structure that provides independence, flexibility, and nimbleness for the organization. Jackson Health System must have a governance model that provides clear lines of accountability to the County government and to the public. Greater accountability is required for the fulfillment of the mission within a sound financial framework, given budgetary restraints, reduced federal and state funding and competitive pressures. The Taskforce recommends that a new governance model, with a diverse board, must be established to remain focused on Jackson Health System's mission and operational and financial performance.

It is the general consensus of the Taskforce that the best governance model for Jackson Health System is for the County to establish a new not for profit corporation to manage and operate Jackson Health System under contract, reserving to the County only certain enumerated powers described in this report or otherwise provided by law.

An implementation committee, with the qualifications, composition and autonomy of the proposed not for profit corporation board, should be formed under the County Code and funded to perform the work necessary for the implementation of the new governance model. The formation of this implementation committee should be immediate and can operate concurrently with the Financial Recovery Board (FRB). It is our intent that the FRB sunset as soon as possible and that the implementation committee will then become the board for governance of Jackson Health System, assuming all the authorities and responsibilities of governance.

Concurrently with creation of this new not for profit corporation, the Taskforce recommends creating a Public Health Advisory Committee to ensure accountability on the use of unique public funds (½ penny surtax funds; ad valorem, maintenance of effort, etc.)[9]; and to ensure that the safety net mission is being met. It will offer recommendations to the Mayor and Board of County Commissioners on improving access, quality and coordination of countywide public health.

The Taskforce recommends the not for profit corporation have a nine member board of directors, initially appointed by the Mayor and the Board of County Commissioners, serving staggered three-year terms with a three term limit. The Mayor's appointments would be subject to ratification by the Board of County Commissioners. For subsequent appointments, the not for

[9] There may be changes necessary to applicable law including but not limited to the Code of Miami-Dade County and State statutes to make the 1/2 penny surtax funds and ad valorem funds available to a not for profit corporation or other entity; a voter referendum may be necessary as well. See Appendices F & G.

profit corporation board will nominate and elect its own membership. Additionally, the Board shall have the power to appoint non-voting ex officio members.

The Taskforce recommends the initial board of directors be comprised of at least one physician, one lawyer, two CFOs/CPAs, and one insurance executive preferably with actuarial experience. The remainder shall be made up of members with extensive backgrounds and expertise in such fields as healthcare executive management, general business, nursing, labor relations, and/or community relations/community affairs.

Furthermore, the Taskforce recommends that the governing board reflect and embrace a rigorous conflict of interest policy which includes a heightened standard, eliminating both the perception of as well as any actual conflict of interest for board members. Board members shall have no conflicts of interest for one year before or after serving personally, or as stakeholders in the outcome of their decisions. The governing body's sole interest should be the future of Jackson Health System.

The immediate family[10] of a member of the board of Jackson Health System, and organizations in which an immediate family member is employed, has control of, or has a material interest in, shall not be engaged to do business with or provide services to Jackson Health System. An immediate family member of a member of the board shall not be employed in a management capacity as a director or above at Jackson Health System. Additionally, the immediate family of the member of the board shall not be employed as senior management, have control of, or have a material interest in an organization that competes with Jackson Health System.

Board member training shall include ethics training.

This heightened standard applies to both the initial and future boards.

The full list of Taskforce recommendations is included in the body of this report.

[10] The term "immediate family" means the spouse, parents, step-parents, brothers and sisters, step-brothers and step-sisters, children and step-children of a governing board member.

I. Introduction

A. Mission. The Miami-Dade County Hospital Governance Taskforce (Taskforce) was created by Board of County Commissioners (BCC) Resolution No. R-30-11, adopted January 20, 2011, which, in part, cited concerns that the Miami-Dade County "Public Health Trust is in the midst of an economic crisis that appears to be due in large part to its governing structure; and …the Miami-Dade County Grand Jury in its report dated August 5th, 2010 specifically determined that the Public Health Trust's 'governance must be changed.'" In Resolution No. R-30-11, the BCC directed the Taskforce to:

> *Study possible models for the governance of the Public Health Trust, including but not limited to (a) operation of the Public Health Trust by a private, not-for-profit 501(c)(3) organization with a board of doctors, nurses, community leaders, and health care professionals, as was done, for example, with Tampa General Hospital; (b) operation of the Public Health Trust by an independent tax district, as was done for the North and South Broward Hospital districts; (c) other models, perhaps blending these models, as the Taskforce may decide; (d) and other recommendations regarding the governance and financing of the Public Health Trust, as the Taskforce may decide. In its deliberations and recommendations, the Taskforce shall at all times keep in mind the importance of protecting the interests of the taxpayers of our community. The Taskforce shall complete its work and file an executive summary of its recommendations with the Clerk of the Board no later than 60 days from the first meeting of the Taskforce and will file a final report no later than 90 days from the first meeting of the Taskforce. The Taskforce will cease to exist 100 days from the first meeting of the Taskforce.*

The resulting timeline, based on the Taskforce's initial meeting on March 28, 2011, required the Taskforce to file an executive summary no later than May 27, 2011 and a final report no later than June 26, 2011. Also, the Taskforce is to cease to exist on July 6, 2011.

A copy of Resolution No. R-30-11 is attached as Appendix A of this report.

B. Membership. The Taskforce consisted of twenty members appointed by individuals or organizations designated in Resolution No. R-30-11. At its first meeting on March 28, 2011, the Taskforce selected Mr. Juan C. Zapata as Chairman and Ms. Susan Dechovitz as Vice Chairperson. The membership list of the Taskforce is listed in Table 1.

Table 1.
Hospital Governance Taskforce Membership List

Member Affiliation	Chosen By	Name
Chief Executive Officer of Baptist Healthcare System, Inc. or a member of its executive management team	Chief Executive Officer	Brian E. Keeley, President/CEO Baptist Health South Florida, Inc.
Chief Executive Officer of Miami-Children's Hospital or a member of its executive management team	Chief Executive Officer	Dr. M. Narendra Kini, President/CEO Miami-Children's Hospital
Chief Executive Officer of HCA Kendall Regional Medical Center or a member of its executive management team	Chief Executive Officer	Lee Chaykin , CEO Kendall Regional Medical Center
Chief Executive Officer of either Hialeah, Northshore Medical Center and Palmetto General Hospital or a member of its executive management team	CEO of Tenet Healthsystems Medical, Inc.	Ana Mederos, CEO Palmetto General Hospital
Chief Executive Officer Mt. Sinai Medical Center or a member of its executive management team	Chief Executive Officer	Steven D. Sonenreich, President/CEO Mount Sinai Medical Center
Chief Executive Officer Mercy Hospital or a member of its executive management team	Chief Executive Officer	Dr. Manuel P. Anton, III President/CEO, Mercy Hospital
Administrator ,or appointee, of the Florida Department of Health-Miami-Dade County Health Department	Administrator	Lillian Rivera, RN, MSN, Ph.D., Administrator, Miami-Dade County Health Department
State Attorney of Miami-Dade County, or designee	State Attorney	Susan Leah Dechovitz Assistant State Attorney Miami-Dade State Attorney's Office
Individual appointed by the Mayor	Mayor	Jose Cancela, Principal Hispanic USA, Inc.
Individual appointed by the BCC	Board of County Commissioners	Steven Pinkert, MD, JD, MBA Pinkert & Marsh, P.A.
Individual appointed by the BCC	Board of County Commissioners	Marisel Losa, President/CEO Health Council of South Florida
Individual appointed by the BCC	Board of County Commissioners	Donna E. Shalala, President University of Miami
Individual appointed by the BCC	Board of County Commissioners	Juan C. Zapata, Director Pazos, Robaina & Zapata Management
Individual appointed by the BCC	Board of County Commissioners	Edward J. Feller, MD
Representative of unions at the Public Health Trust	Board of County Commissioners	Martha Baker, RN, President SEIU Healthcare Florida, Local 1991
Physician who is a member of the Medical Executive Committee of Jackson Memorial Hospital	Other members of the task force	Dr. Michael Barron, President Medical Executive Committee of JMH
Representative or designee from the National Association of Public Hospitals and Health Systems (NAPH) based in Washington, D.C.	National Association of Public Hospitals	Robert Johnson, Representative National Association of Public Hospitals & Health Systems

Table 1.
Hospital Governance Taskforce Membership List

Member Affiliation	Chosen By	Name
Representative of the Florida Nursing Association	Florida Nursing Association	Dr. Sharon Pontious, Representative Florida Nurse's Association
Chief Executive Officer of the Health Foundation of South Florida or a member of its executive management team	Chief Executive Officer	Dr. Steven E. Marcus, President/CEO Health Foundation of South Florida
Chief Executive Officer of the South Florida Hospital & Healthcare Association or a member of its executive management team	Chief Executive Officer	Linda S. Quick, President South Florida Hospital & Healthcare Association

C. Background.

Jackson Health System is an integrated healthcare delivery system licensed for 2,200 beds, has a budget of $2 billion dollars, and is comprised of six hospitals across three campuses. It includes a health plan, primary care clinics, nursing homes, and responsibility for the care of inmates. It is the largest public system in the United States as reported by Becker Hospital Review in August 2010. Jackson Health System had historically been governed by the Public Health Trust, a dedicated team of citizen volunteers appointed by the Miami-Dade Board of County Commissioners.[11] Jackson Health System ensures that all residents of Miami-Dade County receive a single high standard of care, regardless of their ability to pay. It is an academic teaching hospital with a long-standing relationship with the University of Miami and a more recent affiliation with Florida International University.

As cited in Resolution No. R-30-11, the *Final Report of the Miami-Dade County Grand Jury, Fall Term A.D. 2009, re Jackson Health System*, filed August 5, 2010, the Grand Jury determined that the Public Health Trust/Jackson Health System's "governance system must be changed" (p.3).[12] Additionally, it made more than a dozen other recommendations, pp. 32-33, concerning Jackson Health System governance and oversight, including a recommendation for the creation of a group, such as this Taskforce, to study the best governance model for Jackson Health System.

Another document, *Recommendations Regarding Structure and Governance; Report for Jackson Health System*, National Association of Public Hospitals and Health Systems, January 13, 2008, had been prepared two years prior to the Grand Jury report.[13] This document had already provided the Jackson Health System with

[11] Resolution No. R-392-11, adopted May 3, 2011 by the Board of County Commissioners, implemented an assistive measure, pursuant to Section 25(A)-9(C)5 of the Miami-Dade County Code, in the form of establishing a Financial Recovery Board to help resolve the financial sustainability conditions threatening the Public Health Trust
[12] Available online, http://www.miamisao.com/publications/grand_jury/2000s/gj2009f.pdf
[13] Available online, http://www.miamidade.gov/auditor/library/Recommendations_Regarding_Structure_Governance_JHS-NAPH.pdf

extensive information on potentially desirable governance alternatives, much of which remained applicable to the Taskforce's deliberations.

D. Process

Early in its deliberations, the Taskforce considered the appropriateness of initiating a fact-finding investigation regarding Jackson Health System's financial and operational difficulties. The Taskforce decided to focus on the charge of examining alternative governance models which would address issues noted in the previously issued reports, thereby making it feasible to accomplish the Taskforce's mission within the timeframes specified in Resolution No. R-30-11.

Taskforce deliberations and considerations included input from multiple sources, including: national organizations, interviews with selected healthcare system executives from many parts of the country, Jackson Health System executives, available reference materials from professional literature, background research by staff, and extensive input from the Taskforce members themselves.

E. Governance Models – The Taskforce considered each of the following governance models.

a. Direct Operational Control by the County.

b. Direct Operational Control by a University.

c. Public Health Trust with Increased Autonomy.

d. Hospital Authority or Public Benefit Corporation.

e. Taxing District.

f. Not for Profit Organization formed by the County.

g. Hybrid or Multiple Structures.

h. For Profit Corporation Governance.

II. Considerations re: Surtax, Sunshine, Sovereign Immunity, Public Records

There was broad consensus in the Taskforce on the imperative of retaining sovereign immunity and obtaining appropriate exemptions from the Sunshine Law and Public Records requirements so as to enable the new entity to be more competitive in the healthcare marketplace. Nevertheless, the Taskforce recognized the challenges presented by applying government laws such as sovereign immunity to the new not for profit corporation. The relationship between Sunshine Law, Public Records Law, and sovereign immunity requirements is complex. Appendices F & G provide guidance on this subject.

There was equally broad consensus in the Taskforce that maintaining eligibility for the existing ½ penny surtax [Dade County Health Care Improvement Surtax for Jackson Memorial Hospital adopted by referendum in 1991] and ad valorem/general fund support is essential. The Taskforce felt that continued eligibility for the surtax could be dealt with through separate legislative action or contract provisions, as necessary.

III. Presentations and Interviews – Presentations to and interviews by the Taskforce are listed in Table 2. Additional details are available in the minutes of each meeting.

Table 2
Presentations and Interviews

Meeting	Presenter	Subject
March 28, 2011	Commissioner Rebeca Sosa, Board of County Commissioners	Overview of Taskforce background and mission
	Michael Murawski, Advocate, Commission on Ethics and Public	Conflicts of interest and Code of Ethics
	Karon Coleman and Valda Christian, Assistant County Attorneys	Sunshine Law requirements, Taskforce responsibilities and available reference materials
	John Copeland III, Chairman, Public Health Trust	Public Health Trust overview
	Eneida O. Roldan, MD, MPH, MBA, President & CEO, Jackson Health System	Jackson Health System overview, problems and needs
	Ted Shaw, FHFMA, CPA, Chief Transition Officer, Jackson Health System	Key operating indicators and financial outlook
	Pascal J. Goldschmidt, MD, Dean, University of Miami Miller School of Medicine	Relationship between University of Miami Miller School of Medicine and Jackson Health System
April 7, 2011	Larry S. Gage, President, National Association of Public Hospitals and Health Systems/Partner, Ropes & Gray LLP	"Models for Organizational & Structural Reform" presentation
	Jorge L. Arrizurieta, Member, Public Health Trust	Public Health Trust overview and need for change in governance structure
April 14, 2011	Duane J. Fitch, CPA, MBA, Senior Partner, The Sibery Group, LLC	"Hospital Governance Taskforce (HGT) Presentation"; issues and observations relating to governance and the Public Health Trust
	Tom Traylor, Vice President of State, Local, and Federal Programs, Boston Medical Center, Boston, MA	Teleconference interview
	Johnese Spisso, Chief Health Systems Officer, UW Medicine - Harborview Medical Center, Seattle, WA	Teleconference interview
April 21, 2011	Linda Quick, CEO, South Florida Hospital & Healthcare Association/Taskforce Member	Comparison of Federal, State and Local Hospital Funding Sources
	Elizabeth Reidy, General Counsel, Cook County Health & Hospitals System, Chicago, IL	Teleconference interview

Table 2
Presentations and Interviews

Meeting	Presenter	Subject
	John Schunhoff, Chief Deputy Director, Los Angeles County Department of Health Services, Los Angeles, CA	Teleconference interview
	Gerard Grimaldi, Vice President, Health Policy & Government Relations, Truman Medical Centers, Kansas City, MO	Teleconference interview
April 28, 2011	Dr. John R. Combes, President and COO, Center for Healthcare Governance	Hospital governance
	Carlos Migoya, President and CEO Elect, Jackson Health System	Introduction and discussion
May 5, 2011	Karon M. Coleman, Assistant County Attorney	Sunshine Laws, Public Records, Sovereign Immunity and Public Benefit Corporation

IV. Recommendations

Overview

Jackson Health System is a vital community resource that faces tremendous challenges, including finances and its ability to compete in a rapidly evolving healthcare industry. Jackson Health System's mission is in jeopardy under the status quo. Strong steps are needed to address these challenges and to ensure Jackson Health System's future as an integrated healthcare system.

The basic principles underlining the Taskforce recommendations recognize that the Jackson Health System must have a governance structure that provides independence, flexibility, and nimbleness. The new governance model must provide clear lines of accountability to the County government and the public and fulfill their mission within a sound financial framework, given budgetary restraints, reduced federal and state funding and competitive pressures. In this climate, a new governance model with a more diverse board must be established to remain focused on Jackson Health System's mission and operational and financial performance.

Furthermore, Taskforce recommendations should be viewed in their entirety rather than selectively; many recommendations are coupled with others.

There was general consensus that the best way to address the concerns would be the creation of a new not for profit corporation to manage and operate the Jackson Health System. The creation of a not for profit corporation that retains the missions of a safety net health system and an academic teaching hospital has clear analogies in Florida (Tampa General) and in other states (Boston Medical Center, Grady Memorial, Truman Medical Centers, and others).

Issues to consider for the successful implementation of a not for profit model include the degree to which the County can legally transfer all of the necessary financial and operating autonomy (including personnel, financial and procurement autonomy) to the new

corporation. See Appendices F & G for reviews of the issues related to the continued availability of the ½ penny sales surtax and ad valorem/general fund support upon changing from a county public general hospital to any other type of entity. There may also be implications for sovereign immunity and open government laws (Sunshine Law and Public Records Act) when transitioning from a government-run health system to a not for profit run health system. See Appendix G regarding a discussion of Sunshine Law, Public Records Act and Sovereign Immunity.

There was general consensus on creating a Public Health Advisory Committee to ensure accountability on the use of unique public funds (½ penny surtax funds, ad valorem/general fund support, etc.)[14] and to ensure that the safety net mission is being met. It will offer recommendations to the Mayor and Board of County Commissioners on improving access, quality and coordination of countywide public health.

For example, in formation of the Boston Medical Center, the same legislation that formed the Boston Medical Center also created the Boston Public Health Commission to continue the city's public health responsibilities. The Public Health Commission's "mission is to protect, promote, and preserve the health and well-being of all Boston residents, particularly the most vulnerable."[15] The Public Health Commission was encouraged to establish an advisory committee to act as an oversight entity to monitor the providing of health care in Boston, particularly to the city's vulnerable populations.

Mission

1. Set forth a clearly stated mission statement & vision for the health system that reaffirms Jackson Health System's roles as a safety net hospital, academic teaching hospital, and integrated healthcare system with multiple academic relationships.

Board Composition

2. Nine members, with five initial appointments made by the Mayor and four initial appointments made by the Board of County Commissioners. The members shall serve staggered three-year terms with a three term limit: three shall be appointed for three-year terms, three for two-year terms, and three for one-year terms, with duration of initial terms determined by lottery. For subsequent appointments, the not for profit corporation board will nominate and elect its own membership.

3. The Taskforce recommends the initial board of directors be comprised of at least one physician, one lawyer, two CFOs/CPAs, and one insurance executive preferably with actuarial experience. The remainder shall be made up of members with extensive backgrounds and expertise in such fields as healthcare executive management, general business, nursing, labor relations, and/or community relations/community affairs.

[14] There may be changes necessary to applicable law including but not limited to the Code of Miami-Dade County and State statutes to make the 1/2 penny surtax funds and ad valorem funds available to a not for profit corporation or other entity; a voter referendum may be necessary as well. See Appendices F & G.
[15] Extract from Boston Public Health Commission website, www.bphc.org/about/officedirector/Pages/Home.aspx

4. We urge inclusion of diversity in the governing body.

5. The new governing board shall have the power to appoint non-voting ex officio members at its sole discretion.

Ethics

6. The governing board shall reflect and embrace a rigorous conflict of interest policy which includes a heightened standard, eliminating both the perception of as well as any actual conflict of interest for board members. Board members shall have no conflicts of interest for one year before or after serving, personally or as stakeholders, in the outcome of their decisions. The governing body's sole interest should be the future of Jackson Health System.

   The immediate family[16] of a member of the board of Jackson Health System, and organizations in which the immediate family is employed, has control of, or has a material interest in, shall not be engaged to do business with or provide services to Jackson Health System. The immediate family of a member of the board shall not be employed in a management capacity as a director or above at Jackson Health System. Additionally, the immediate family of the member of the board shall not be employed as senior management, have control of, or have a material interest in an organization that competes with Jackson Health System.

   Board member training shall include ethics training.

   This heightened standard applies to both the initial and future boards.

Legal Structure and Governance

7. Establish a new not for profit corporation to manage and operate Jackson Health System, reserving to the County only certain enumerated powers described herein or otherwise provided by law.

8. Provide sovereign immunity. Every effort should be made to structure the not for profit corporation in such a way so as to preserve the applicability of the sovereign immunity statute, including pursuing legislative changes. For example, the governing body of Jackson Health System and the County should investigate the possibility of pursuing legislative changes similar to the changes approved for Shands Teaching Hospital and Clinics in the 2011 Florida legislative session, if legally appropriate.[17]

9. Concurrently with creation of this new not for profit corporation, the Taskforce recommends creating a Public Health Advisory Committee to ensure accountability on the use of unique public funds (½ penny surtax funds; ad valorem/general fund support,

[16] The term "immediate family" means the spouse, parents, step-parents, brothers and sisters, step-brothers and step-sisters, children and step-children, of a governing board member.

[17] CS/CS/HB 395 amended Section 1004.41 of Florida Statutes, pertaining to Shands Teaching Hospital and Clinics, and provided sovereign immunity specifically for Shands. However, it should be noted that Shands Hospital is a creation of the state, pursuant to Section 1004.41 of Florida Statutes while Jackson Health System is a county created health system.

etc.)[18]; and to ensure that the safety net mission is being met. It will offer recommendations to the Mayor and Board of County Commissioners on improving access, quality and coordination of countywide public health.

The Public Health Advisory Committee shall include members appointed by the Mayor and the Board of County Commissioners. One of the persons appointed shall be the Director of the Miami-Dade County Health Department or the Director's designee. The other members shall have extensive expertise in healthcare issues and shall not be County or Jackson Health System employees.

10. The Jackson Health System auditor shall be required to annually provide certification and explanation that all ad valorem/general fund support and surtax revenues that are received are used for the purposes for which they were legally intended.

11. Ensure Jackson Health System remains eligible for Disproportionate Share Hospital (DSH) funding.

Authorities and Responsibilities Retained by the Board of County Commissioners

12. Retain ownership and be responsible for the maintenance of the real property[19] currently owned by the County and used by Jackson Health System.

13. Retain the responsibility for approval of any sale, transfer, destruction, replacement, abandonment, or related disposition of currently County-owned real property as referred to in paragraph 12 above.

14. To the extent possible, retain the responsibility for approval of any issuance of capital bonds under the authority of the County requested by Jackson Health System.

Authorities and Responsibilities Reserved to Health System Governing Board

15. All other authority and responsibility not specifically reserved to the County shall be exercised by the governing board including but not limited to:
    - Hire, fire, evaluate, and set compensation of the health system's CEO;
    - Establish by-laws;
    - Make decisions regarding human resources, purchasing, growth or reduction decisions of medical services, contracts and payments to academic institutions, etc.;
    - Develop and establish policies;
    - Conduct long range strategic planning;
    - Approve pay and compensation policies for its executive team and policies for employed physicians and employees;

[18] There may be changes necessary to applicable law including but not limited to the Code of Miami-Dade County and State statutes to make the 1/2 penny surtax funds and ad valorem funds available to a not for profit corporation or other entity; a voter referendum may be necessary as well. See Appendices F & G.

[19] Currently, the Public Health Trust has the responsibility to maintain the facilities, not the County. See 25A-4(d) of Miami-Dade County Code.

- Meet all local, state and national standards governing hospitals and health systems;
- Annually, provide to the Mayor and Board of County Commissioners audited financial reports and an annual report on the operations and services of Jackson Health System with particular emphasis on care, quality and services provided to indigent residents of Miami-Dade County;
- Approve the health systems operating, capital equipment and facilities budgets;
- Develop and enter into affiliation agreements with academic and other organization necessary to carry out the mission of the health system; and
- Approve labor and collective bargaining agreements.

Culture

16. Quoting from a recent study by the Health Research & Educational Trust in partnership with the American Hospital Association,

    Creating a culture of performance excellence, accountability for results, and leadership execution are the keys to success….a culture of performance excellence and accountability for results was strongly exhibited during the interviews with the high performing health systems. This was best defined through cultural markers such as: focusing on continuous improvement, driving towards dramatic improvement or perfection versus incremental change, emphasizing patient-centeredness, adopting a philosophy that embraces internal and external transparency with regard to performance, and a having a clear set of defined values and expectations that form the basis for accountability of results. The other finding connected with the culture of performance excellence was a disciplined and persistent focus by leadership on execution and implementation to achieve the lofty goals. The culture of performance and excellence was strongly connected to leadership's execution doctrine.[20]

    Adapting this study's findings to Jackson Health System's situation, the Taskforce recommendation is that the governing body shall focus on continuous improvement, driving towards dramatic improvement or perfection versus incremental change, emphasizing patient-centeredness, adopting a philosophy that embraces both internal and external transparency, which include such things as performance, efficiency, innovation, and a having a clear set of defined values and expectations that form the basis for accountability for results, innovation, strategic vision, sustaining the mission and values.

Implementation

17. We urge that an aggressive timetable be set to implement the recommendations of this Taskforce and that it be done with a sense of urgency.

18. An implementation committee, with the qualifications, composition and autonomy of the proposed not for profit corporation board, should be formed under the County Code and

[20] Yonek J., Hines S., and Joshi M. *A Guide to Achieving High Performance in Multi-Hospital Health Systems*. p. 1, Health Research & Educational Trust, Chicago, IL. March 2010. Available online: http://www.hret.org/quality/projects/resources/highperformance.pdf

funded to perform the work necessary for the implementation of the new governance model. The implementation committee will then become the board for governance of Jackson Health System. The formation of this implementation committee should be immediate and can operate concurrently with the FRB. It is our intent that the FRB sunset as soon as possible and that the implementation committee will then become the board for governance of Jackson Health System, assuming all the authorities and responsibilities of governance.

V. Comments

The Taskforce recommends that the Sunshine Law and Public Records Act (applicable to public hospitals/healthcare) be amended as necessary to enable a more sustainable business model.

MEMORANDUM

Amended
Agenda Item No. 11(A)(4)

TO: Honorable Chairman Joe A. Martinez
and Members, Board of County Commissioners

DATE: January 20, 2011

FROM: R. A. Cuevas, Jr.
County Attorney

SUBJECT: Resolution establishing the Miami-Dade County Hospital Governance Taskforce to study and report on alternative models for operating the Public Health Trust to ensure it has the governing and financial structure necessary to fulfill its crucial mission

Resolution No. R-30-11

The accompanying resolution was prepared and placed on the agenda at the request of Prime Sponsor Commissioner Rebeca Sosa.

R. A. Cuevas, Jr.
County Attorney

RAC/jls

MEMORANDUM

(Revised)

TO: Honorable Chairman Joe A. Martinez and Members, Board of County Commissioners

DATE: January 20, 2011

FROM: R. A. Cuevas, Jr. County Attorney

SUBJECT: Amended Agenda Item No. 11(A)(4)

Please note any items checked.

_____ **"3-Day Rule" for committees applicable if raised**

_____ **6 weeks required between first reading and public hearing**

_____ **4 weeks notification to municipal officials required prior to public hearing**

_____ **Decreases revenues or increases expenditures without balancing budget**

_____ **Budget required**

_____ **Statement of fiscal impact required**

_____ **Ordinance creating a new board requires detailed County Manager's report for public hearing**

_____ **No committee review**

_____ **Applicable legislation requires more than a majority vote (i.e., 2/3's ____, 3/5's ____, unanimous _____) to approve**

_____ **Current information regarding funding source, index code and available balance, and available capacity (if debt is contemplated) required**

Approved _____ Mayor
Veto _____
Override _____

Amended
Agenda Item No. 11(A)(4)
1-20-11

RESOLUTION NO. R-30-11

RESOLUTION ESTABLISHING THE MIAMI-DADE COUNTY HOSPITAL GOVERNANCE TASKFORCE TO STUDY AND REPORT ON ALTERNATIVE MODELS FOR OPERATING THE PUBLIC HEALTH TRUST TO ENSURE IT HAS THE GOVERNING AND FINANCIAL STRUCTURE NECESSARY TO FULFILL ITS CRUCIAL MISSION

WHEREAS, the Public Health Trust is in the midst of an economic crisis that appears to be due in large part to its governing structure; and

WHEREAS, the Miami-Dade County Grand Jury in its report dated August 5th, 2010 specifically determined that the Public Health Trust's "governance must be changed," explaining "the path to survival requires a change in the governance model for JHS. Without that level of change, we are asking for this financial disaster to repeat itself, over and over again;" and

WHEREAS, other communities have changed the governing and financial structure of their public general hospitals from a government board to a private, not-for-profit 501(3) organization with a board of doctors, community leaders, and health care professionals, as was done, for example, with Tampa General Hospital; and

WHEREAS, still other communities have changed the governing and financial structure of their public general hospital from a county board to an independent tax district, as was done for the North and South Broward Hospital districts; and

WHEREAS, it will benefit members of the Board of County Commissioners and the people and communities of Miami-Dade County to understand the feasibility and benefits of

these and other models of governance as the Board and the community continue to address the economic crisis at the Public Health Trust; and

WHEREAS, the private hospitals in Miami-Dade County have an immense stake in the continued financial and economic success of the Public Health Trust because, if the Public Health Trust is forced to cutback on the number of indigent patients that it treats, a greater number of indigents will appear at the emergency rooms of the private hospitals and the private hospitals will be forced to provide more care to indigents from their own resources,

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF MIAMI-DADE COUNTY, FLORIDA, that the Miami-Dade County Hospital Governance Taskforce is hereby created:

Section 1. The Taskforce shall study possible models for the governance of the Public Health Trust, including but not limited to (a) operation of the Public Health Trust by a private, not-for-profit 501(c)(3) organization with a board of doctors, nurses, community leaders, and health care professionals, as was done, for example, with Tampa General Hospital; (b) operation of the Public Health Trust by an independent tax district, as was done for the North and South Broward Hospital districts; (c) other models, perhaps blending these models, as the Taskforce may decide; (d) and other recommendations regarding the governance and financing of the Public Health Trust, as the Taskforce may decide. In its deliberations and recommendations, the Taskforce shall at all times keep in mind the importance of protecting the interests of the taxpayers of our community. The Taskforce will complete its work and file an executive summary of its recommendations with the Clerk of the Board no later than 60 days from the first meeting of the Taskforce and will file a final report no later than 90 days from the

first meeting of the Taskforce. The Taskforce will cease to exist 100 days from the first meeting of the Taskforce.

Section 2. Staff for the Taskforce will be provided by the Commission Auditor and additional staff will be provided by the Mayor or Mayor's designee. In addition, the Mayor or Mayor's designee is requested and directed to provide the Taskforce any information or analysis it may request, including from sources such as the County Manager's Office and the Finance Department. The Mayor or Mayor's designee is directed to provide the Taskforce with meeting facilities and appropriate physical and technical support, including equipment necessary to comply with the Sunshine laws.

Section 3. The County Attorney's Office will provide legal advice and guidance to the Taskforce.

Section 4. The Taskforce shall consist of twenty (20) members as follows:

(1) The chief executive officer of Baptist Healthcare Systems, Inc. or a member of its executive management team chosen by the chief executive officer;

(2) The chief executive officer of Miami-Children's Hospital or a member of its executive management team chosen by the chief executive officer;

(3) The chief executive officer of HCA Kendall Regional Medical Center or a member of its executive management team chosen by the chief executive officer;

(4) A chief executive officer of either Hialeah, Northshore Medical Center and Palmetto General Hospital, or a member of their executive management teams chosen by the chief executive officer of Tenet Healthsystems Medical, Inc.;

(5) The chief executive officer of Mt. Sinai Medical Center or a member of its executive management team chosen by the chief executive officer;

(6) The chief executive officer of Mercy Hospital (or its successor hospital or a member of its executive management team chosen by the chief executive officer;

(7) The Administrator, or appointee, of the Florida Department of Health-Miami-Dade County Health Department;

(8) The State Attorney of Miami-Dade County, or designee;

(9) One person appointed by the Mayor;

(10) Five persons chosen by the Board of County Commissioners, including four persons with backgrounds in health care, finance, law, or procurement, including one person who is a current or former chief financial officer of a successful local hospital or hospital system; and a fifth person who is an academic or expert in the area of healthcare;

(11) One representative of the unions at the Public Health Trust chosen by the Board of County Commissioners;

(12) A physician who is a member of the medical executive committee of Jackson Memorial Hospital, chosen by the other members of the Taskforce;

(13) A representative, or designee, from the National Association of Public Hospitals and Health Systems ("NAPH") based in Washington, D.C., chosen by the NAPH;

(14) A representative of the Florida Nursing Association, chosen by the Florida Nursing Association;

(15) The chief executive officer of Health Foundation of South Florida or a member of its executive management team chosen by the chief executive officer; and

(16) The chief executive officer of South Florida Hospital & Healthcare Association or a member of its executive management team chosen by the chief executive officer.

Because of the vital importance of this project, the chief executive officers of the hospitals, foundations, and associations named above are strongly encouraged to serve personally on the committee. In the event that chief executive officers cannot serve personally,

they are encouraged to select an equivalent member from the top of their executive management teams.

Any appointment, choice, or assignment of a designee under this section must be documented by the filing of a written record making the appointment, choice, or assignment with the Clerk of the Commission.

The Prime Sponsor of the foregoing resolution is Commissioner Rebeca Sosa. It was offered by Commissioner **Rebeca Sosa**, who moved its adoption. The motion was seconded by Commissioner **Carlos A. Gimenez** and upon being put to a vote, the vote was as follows:

Joe A. Martinez, Chairman		aye	
Audrey M. Edmonson, Vice Chairwoman		aye	
Bruno A. Barreiro	aye	Lynda Bell	aye
Jose "Pepe" Diaz	aye	Carlos A. Gimenez	aye
Sally A. Heyman	absent	Barbara J. Jordan	absent
Jean Monestime	absent	Dennis C. Moss	absent
Natacha Seijas	nay	Rebeca Sosa	aye
Sen. Javier D. Souto	aye		

The Chairperson thereupon declared the resolution duly passed and adopted this 20th day of January, 2011. This resolution shall become effective ten (10) days after the date of its adoption unless vetoed by the Mayor, and if vetoed, shall become effective only upon an override by this Board.

MIAMI-DADE COUNTY, FLORIDA
BY ITS BOARD OF
COUNTY COMMISSIONERS

HARVEY RUVIN, CLERK

By: **DIANE COLLINS**
Deputy Clerk

Approved by County Attorney as
to form and legal sufficiency.

TWL

Thomas W. Logue

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REVISED 3/25/11

Miami-Dade County Hospital Governance Taskforce (HGT)

Meeting of Monday, March 28, 2011 at 8:30 a.m.
The Beacon Council
80 SW 8th Street, Suite 2400
Miami, Florida

AGENDA

	Moderator	Mr. Charles Anderson, *Commission Auditor*
1.	Self Introduction of Members	
2.	Opening Statement	The Hon. Rebeca Sosa, *Commissioner, District 6*
3.	Presentations	
	Commission on Ethics & Public Trust	Mr. Robert Meyers, *Executive Director*
	County Attorney's Office	Mr. Eugene Shy & Ms. Valda Christian, *Asst. County Attorneys*
	Overview of the Public Health Trust (PHT)	Mr. John H Copeland, III, *Chairperson, PHT*
	Historical Overview & Presentation on Jackson Health System (JHS)	Dr. Eneida O. Roldan, *President & Chief Executive Officer, JHS* & Mr. Ted Shaw, C*hief Transition Officer, JHS*
4.	Relationship between UM and JHS	Dr. Pascal J. Goldschmidt, *Dean, Medical School, UM* & Mr. Ted Shaw, *Chief Transition Officer, JHS*
5.	Organization and Structure of Task Force - Selection of Chair and Vice Chair - Selection of additional HGT member *(R-30-11, Sec. 4 #12)* - Meeting Schedules - Decision: Who should write final recommendations for BCC?	
6.	Any Other Matters	
7.	Closing Remarks	Newly Selected Chairperson

HGT related Information can be found at http://www.miamidade.gov/auditor/hospital_governance.asp

REVISED

HGT

Miami-Dade County Hospital Governance Taskforce

Chairperson
Juan C. Zapata

Vice Chairperson
Susan Dechovitz

Members
Manual P. Anton, III
Martha Baker
Jose Cancela
Lee Chaykin
Ed Feller
Robert Johnson
Brian E. Keeley
M. Narendra Kini
Marisel Losa
Steven Marcus
Ana Mederos
Linda Quick
Steven Pinkert
Sharon Pontious
Lillian Rivera
Donna Shalala
Steven Sonenreich

Website:
http://www.miamidade.gov/auditor/hospital_governance.asp

Staff Contact:
S. Donna Palmer, Coordinator
Office of the Commission Auditor
(305) 375-2524
spalmer@miamidade.gov

Meeting of Thursday, April 7, 2011 at 3:00 p.m.

HOSPITAL GOVERNANCE TASKFORCE (HGT)

THE BEACON COUNCIL
80 SW 8th Street, Suite 2400
Miami, Florida

AGENDA

I. ROLL CALL

II. APPROVAL OF MINUTES - *Meeting of March 28, 2011*

III. OPENING REMARKS - *Chairperson Juan C. Zapata*
- Announce New Designee – NAPH
- Highlights from Sunshine Meeting held Tuesday, April 5, 2011

IV. ACTION ITEM

A. **SELECTION OF NEW MEMBER** - *(a physician who is a member of the medical executive committee of Jackson Memorial Hospital)*

V. PRESENTATIONS

A. Mr. Larry Gage, President, NAPH
Question & Answer Session

B. Ms. Karon Coleman, Assistant County Attorney
Question & Answer Session

VI. DISCUSSION ITEMS

A. **WHETHER THE HGT SHOULD SEND A LETTER TO GOVERNOR RICK SCOTT –** *Requesting the $35 million in federal stimulus money for Jackson Memorial Hospital*

B. **RESIGNATION LETTER FROM DR. MARK C. ROGERS, FORMER PHT MEMBER –** *(Added at the request of HGT Member Jose Cancela)*

VII. OTHER MATTERS

A. **FUTURE MEETING LOCATIONS**

VIII. ADJOURNMENT

REVISED 4/14/11

HGT

Miami-Dade County Hospital Governance Taskforce

Chairperson
Juan C. Zapata

Vice Chairperson
Susan Dechovitz

Members
Manual P. Anton, III
Martha Baker
Michael Barron
Jose Cancela
Lee Chaykin
Ed Feller
Robert Johnson
Brian E. Keeley
M. Narendra Kini
Marisel Losa
Steven Marcus
Ana Mederos
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Staff Contact:
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Office of the Commission Auditor
(305) 375-4573
spalmer@miamidade.gov

Meeting of Thursday, April 14, 2011 at 3:00 p.m.

HOSPITAL GOVERNANCE TASKFORCE (HGT)

State Attorney's Office
1350 NW 12th Avenue
4th Floor Conference Room
Miami, Florida

AGENDA

I. ROLL CALL

II. OPENING REMARKS - *Chairperson Juan C. Zapata*

III. PRESENTATION

A. The Sibery Group, LLC
Mr. Duane J. Fitch, CPA, MBA, Senior Partner

IV. TELECONFERENCE INTERVIEWS

A. Boston Medical Center, Boston, Massachusetts
Mr. Tom Traylor, Vice President of State, Local, and Federal Programs

B. UW Medicine - Harborview Medical Center, Washington, Seattle
Ms. Johnese Spisso, Chief Health Systems Officer

V. DISCUSSION ITEMS

A. **RESIGNATION LETTER FROM DR. MARK C. ROGERS, FORMER PHT MEMBER –** *(Added at the request of HGT Member Jose Cancela)*

B. **JUNIPER ADVISORY- FIRM OVERVIEW** – *(Added by HGT Chair Juan Zapata)*

VI. OTHER MATTERS

VII. ADJOURNMENT

HGT

Miami-Dade County Hospital Governance Taskforce

Chairperson
Juan C. Zapata

Vice Chairperson
Susan Dechovitz

Members
Manuel P. Anton, III
Martha Baker
Michael Barron
Jose Cancela
Lee Chaykin
Ed Feller
Robert Johnson
Brian E. Keeley
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Marisel Losa
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Staff Contact:
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Office of the Commission Auditor
(305) 375-4573
spalmer@miamidade.gov

Meeting of Thursday, April 21, 2011 at 3:00 p.m.

HOSPITAL GOVERNANCE TASKFORCE (HGT)

The Beacon Council
80 SW 8th Street, 24th Floor
(The Chase Building - Brickell Area)
Miami, Florida

AGENDA

I. ROLL CALL

II. OPENING REMARKS - *Chairperson Juan C. Zapata*

III. APPROVAL OF MINUTES – *Meeting of April 7, 2011*

IV. TELECONFERENCE INTERVIEWS *(30 min. each)*

A. Cook County Health & Hospitals System, Chicago, IL
Ms. Elizabeth Reidy, General Counsel

B. LA County Department of Health Services, Los Angeles, CA
Mr. John Schunhoff, Chief Deputy Director

C. Truman Medical Centers, Kansas City, MO
Mr. Gerard Grimaldi, Vice President, Health Policy & Government Relations

V. OVERVIEW *(10 min.)*

A. Comparison of Federal, State and Local Hospital Funding Sources
(At the request of HGT Member Linda Quick)

VI. WORKING ITEM *(remainder of meeting)*

A. Discuss/Draft Preliminary Recommendations

VII. ADJOURNMENT

HGT

Miami-Dade County Hospital Governance Taskforce

Chairperson
Juan C. Zapata

Vice Chairperson
Susan Dechovitz

Members
Manuel P. Anton, III
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Staff Contact:
S. Donna Palmer, Coordinator
Office of the Commission Auditor
(305) 375-4573
spalmer@miamidade.gov

Meeting of Thursday, April 28, 2011 at 3:00 p.m.

HOSPITAL GOVERNANCE TASKFORCE (HGT)

State Attorney's Office
1350 NW 12th Avenue
4th Floor Conference Room
Miami, Florida

AGENDA

I. ROLL CALL

II. OPENING REMARKS - *Chairperson Juan C. Zapata*

III. APPROVAL OF MINUTES – *Meeting of April 14, 2011*

IV. TELECONFERENCE PRESENTATION *(30 min.)*
Dr. John R. Combes, President and COO
Center for Healthcare Governance, Chicago, IL

V. INTRODUCTION AND DISCUSSIONS *(30 min.)*
Mr. Carlos Migoya, President Elect, Jackson Memorial Hospital

VI. WORKING ITEM *(remainder of meeting)*

Discuss/Draft Preliminary Recommendations

VII. ADJOURNMENT

HGT

Miami-Dade County Hospital Governance Taskforce

Chairperson
Juan C. Zapata

Vice Chairperson
Susan Dechovitz

Members
Manuel P. Anton, III
Martha Baker
Michael Barron
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Staff Contact:
S. Donna Palmer, Coordinator
Office of the Commission Auditor
(305) 375-4573
spalmer@miamidade.gov

Meeting of Thursday, May 5, 2011 at 3:00 p.m.

HOSPITAL GOVERNANCE TASKFORCE (HGT)

Miami-Dade County Health Department
Center of Excellence
8600 NW 17th Street
Miami, FL 33126

AGENDA

I. ROLL CALL

II. OPENING REMARKS - *Chairperson Juan C. Zapata*

III. APPROVAL OF MINUTES – *Meeting of April 21, 2011*

IV. WORKING ITEM

Discuss/Draft Preliminary Recommendations

V. ADJOURNMENT

HGT

Miami-Dade County Hospital Governance Taskforce

Chairperson
Juan C. Zapata

Vice Chairperson
Susan Dechovitz

Members
Manuel P. Anton, III
Martha Baker
Michael Barron
Jose Cancela
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Staff Contact:
S. Donna Palmer, Coordinator
Office of the Commission Auditor
(305) 375-4573
spalmer@miamidade.gov

Meeting of Thursday, May 12, 2011 at 3:00 p.m.

HOSPITAL GOVERNANCE TASKFORCE (HGT)

Miami-Dade County Health Department
Center of Excellence
8600 NW 17th Street
Miami, FL 33126

AGENDA

I. ROLL CALL

II. OPENING REMARKS - *Chairperson Juan C. Zapata*

III. APPROVAL OF MINUTES – *Meeting of April 28, 2011*

IV. WORKING ITEM

Edit/Approve Final Report

V. OTHER MATTERS

VI. CLOSING REMARKS - Chairperson Juan C. Zapata

VII. ADJOURNMENT

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MIAMI-DADE COUNTY
FINAL OFFICIAL MINUTES
Hospital Governance Task Force

Board of County Commissioners
Stephen P. Clark Government Center
Commission Chambers
111 N.W. First Street
Miami, Florida 33128

March 28, 2011
As Advertised

Harvey Ruvin, Clerk
Board of County Commissioners

Diane Collins, Division Chief
Clerk of the Board Division

Mary Smith-York, Commission Reporter
(305) 375-1598

CLERK'S SUMMARY AND OFFICIAL MINUTES
MIAMI-DADE COUNTY HOSPITAL GOVERNANCE TASKFORCE
MARCH 28, 2011

The Miami-Dade County Hospital Governance Taskforce (HGT) convened a meeting at the Offices of The Beacon Council, 80 S.W. 8th Street, Suite 2400, Miami, Florida, on Monday, March 28, 2011, at 8:30 a.m., there being present members: Manuel P. Anton, III; Martha Baker, Jose Cancela, Susan Dechovitz, Lee Chaykin, Ed Feller, Larry Gage, Brian Keeley, M. Narendra Kini; Marisol Losa; Steven Marcus; Ana Mederos; Steven Pinkert; Sharon Pontious; Alternate member Jaime Caldwell representing Linda Quick; Lillian Rivera; Donna Shalala; Alternate member Amy Perry representing Steven Sonenreich; and Juan Carlos Zapata; (Members Linda Quick and Mr. Steven Sonenreich were absent).

ROLL CALL:
The following staff members were present: Commission Auditor Charles Anderson; Assistant County Attorneys Eugene Shy, Valda Clark Christian, Karon Coleman, and Laura Llorente; Michael Murawski, Commission on Ethics & Public Trust; S. Donna Palmer, Office of Commission Auditor; and Deputy Clerk, Mary Smith-York.

Mr. Charles Anderson, Commission Auditor, called the meeting to order and welcomed everyone to today's (3/28) meeting. He recognized Honorable Commissioner Rebeca Sosa and expressed his appreciation for her leadership and dedication to resolving the issues facing Jackson Health Systems.

1. SELF INTRODUCTION OF MEMBERS:

2. OPENING STATEMENT:
Honorable Commissioner Rebeca Sosa greeted attendees and expressed her appreciation to the Hospital Governance Taskforce (HGT) members for serving as part of this professional group. She presented the reason this task force was created and explained how each member was selected to serve in accordance with his/her area of expertise. Commissioner Sosa expressed special thanks to State Attorney Katherine Fernandez Rundle for her part in creating the task force as a result of the Miami-Dade County Grand Jury's final report concerning Jackson Health System. She provided a brief overview of the HGT's purpose to examine alternative measures and to review models from other hospitals' approaches to governance and make recommendations to the Board of County Commissioners (BCC). Commissioner Sosa expressed her appreciation to the BCC for approving the resolution that created this task force, and to Susan Dechovitz and the State Attorney's Office for their support in bringing this idea into fruition. She emphasized the importance of this function being free of political influence and pointed out that she would leave the meeting immediately following her remarks.

Following Ms. Susan Dechovitz' remarks commending Commissioner Sosa for her courage in coming forward to bring this important issue before the BCC in response to the Grand Jury's Final Report, Commissioner Sosa exited the meeting.

Mr. Anderson presented the order of the day and asked that each member state his/her name and organization affiliation, for the record, before delivering comments or presentations.

3. PRESENTATIONS

Commission on Ethics & Public Trust:
Mr. Michael Murawski, Advocate, Commission on Ethics and Public Trust, distributed to each member a copy of the Conflict of Interest and Code of Ethics, along with a breakdown of the members' responsibilities as board members. He then provided a brief historical overview of the creation of the Miami-Dade Office of Commission on Ethics and Public Trust (COE) in 1996, and its purpose. He noted the COE was created by voters and, therefore, was part of the County's Home Rule Charter. Mr. Murawski advised that the three missions of the COE were to: 1) Provide outreach and training to various groups, boards, etc., 2) Enforce the code, and 3) Give opinions and advice. He highlighted Section 2-11.1, No. 4, (a) Advisory Personnel, and noted the HGT would have limited exclusion from contracting with the County, be required to file financial disclosures and adhere to gifts reporting policies. Mr. Murawski pointed out that Page 15, Subsection (r) "Ethics Commission to render opinions on request," was of utmost importance, and encouraged members to feel free to call the COE for assistance.

County Attorney's Office
. Assistant County Attorney Karon Coleman presented a brief overview of the Sunshine Law and Public Records. She advised members that the Government in the Sunshine and the Public Records Laws applied to their activities while serving on the HGT. She noted her memorandum, provided as a handout today, entitled "Sunshine Law & Public Records," outlined the basic principles for members' reference. Ms. Coleman invited members to approach her colleagues: Assistant County Attorneys Eugene Shy, Valda Clark Christian, Laura Llorente, as well as herself with any questions pertaining to the referenced laws. She read, into the record, the basic principles of the Sunshine Law as reflected in the aforementioned handout, along with detailed explanations. Ms. Coleman congratulated HGT members on their appointments to this board and wished them well.

Assistant County Attorney Eugene Shy asked Assistant County Attorney Valda Clark Christian to provide members with an overview of their responsibilities and information that was being made available for members.

Assistant County Attorney Valda Clark Christian reviewed the resources that were available to members on the Commission Auditor's Website at www.miamidade.gov/auditor/hospitalgovernance.asp. She noted this Website contained various documents, including legal statutes and ordinances. Ms. Clark Christian stated a copy of the Miami-Dade County Home Rule Charter was also available at this site, along with a copy of Section 25-A of the Miami-Dade County Code, which concerned the Public Health Trust (PHT). Additionally, she noted a copy of Chapter 155 of the Florida Statutes, regarding the sale or lease of hospitals, as well as County Resolution R-30-11,

establishing this Hospital Governance Taskforce, were also available. Ms. Clark Christian noted other information available on the Website included: various legal opinions related to financial and service matters; the Final Report of the Grand Jury; issues related to public hospitals before the Florida Legislature this Session; articles regarding governance of hospitals, both general and public; and materials related to Steward Health Care, LLC's (Steward's) Proposal relevant to the PHT.

In response to Ms. Susan Dechovitz' inquiry of whether the County's and/or the Florida Legislature's level of authority over Jackson Health System was documented, Ms. Clark Christian noted the referenced memorandum dated February 25, 2010, related to the County Commission's authority and/or responsibility, with respect to the PHT.

Regarding Ms. Dechovitz' question of whether documents relating to offers by companies, other than Steward's proposal were submitted Assistant County Attorney Eugene Shy advised that he believed other such documents had been submitted to Commission Chairman Joe Martinez. Mr. Shy noted he would make those documents available to each taskforce member as quickly as possible.

Ms. Dechovitz asked that the County Attorney's Office also provide HGT members with continuous updates regarding the proposed legislation relating to hospitals that was currently before the Florida Legislature.

Overview of the Public Health Trust (PHT)

Mr. John Copeland, III, Chairperson, Public Health Trust, expressed appreciation for this opportunity to be a part of this important effort and congratulated taskforce members on their appointments. He emphasized the importance of an early evaluation of how to fix this broken business model and noted a requirement of a solution must include the core business issue as an integral part of the agenda. Mr. Copeland provided a brief historical overview of the PHT, highlighting the following points:

- Creation of the Trust in 1973;
- Governing Body of the Board of Trustees; and
- Powers and duties of the Trust, with the exception of anything with respect to: land and assets; collective bargaining; and final budget approval and healthcare policies.

Mr. Copeland referred members to Chapter 25-A of the County Code for information regarding the special relationship the PHT had with the University of Miami (UM). He pointed out that Chapter 25-A stipulated that any amendments made to the By-laws were valid only upon approval by the Board of County Commissioners. Mr. Copeland noted the composition, size, and responsibilities of the PHT were changed in 2003 when Chapter 25-A underwent a major overhaul, and the Office of Countywide Healthcare Planning was created, under the Office of the County Manager, redefining Jackson's focus solely on planning facilities within the system. Mr. Copeland noted the PHT Board consisted of 17 citizen volunteer members, who were fully committed to Jackson Health System's long-term sustainability. He pointed out that the PHT provided leadership for joint planning between Jackson Health System, University of Miami, Miller School of

Medicine, Florida International University, Herbert Wertheim College of Medicine, Miami-Dade County, and other private and community organizations. Mr. Copeland stated the PHT continued to operate a world class facility recognized for its medical excellence, in spite of the challenges faced over the past 18 months. He advised that JHS' capital needs included the current cash crisis; impending challenges of local, state, and federal levels with respect to funding; anticipated increases in the cost of care; and an aging infrastructure; totaling more than $1 billion. Mr. Copeland stated a workable solution would need to include resources that funded the mission of covering all community services provided. He noted some of the PHT's objectives included continuing to look for ways to reduce expenses, becoming as efficient as possible, creating a competitive cost structure, aligning better operations with its academic partners, and optimizing contributions from the profitable service lines. Commenting that these fiscal challenges were not unique to the PHT, Mr. Copeland encouraged HGT members to consider models from around the country in their research. He noted he looked forward to working with the HGT and invited members to present him with any of their questions or concerns.

Historical Overview & Presentation on Jackson Health System (JHS)

Dr. Eneida Roldan, President and Chief Executive Officer, Jackson Health System, provided a brief oral presentation of the history and current status of JHS, including the challenges, serving Miami-Dade County for more than 90 years. She described JHS as an integrated healthcare delivery system with 2,200 beds and a $2 billion budget. Additionally, Dr. Roldan noted JHS was comprised of six hospitals across three campuses, and included a Health Plan, Primary Care Clinics, Nursing Homes, and Inmate Care. She explained the operations and services provided at Jackson Memorial Hospital's main campus and its affiliation with the University of Miami/Miller School of Medicine. Dr. Roldan referenced the half-penny tax referendum that was approved by County residents in 1991, to provide quality care in trauma, burns, children's and other needed medical services. She discussed JHS' 2001 acquisition of Jackson South Community Hospital (formerly Deering) and 2006 acquisition of Jackson North Medical Hospital (formerly Parkway). Dr. Roldan noted that since its inception in 1982 to the present, Jackson Memorial Hospital had continued to fulfill a mission of service to everyone regardless of their ability to pay. She indicated this mission was costly in view of the current national economic downturn and the rapidly changing healthcare industry. Dr. Roldan noted JHS had experienced the same challenges from governance, operations, and a mission of providing services with little resources from the 1970s to today. She commented on a report by the Institute of Medicine last week that listed Miami as having a sicker population than any other city in the U.S. She pointed out that in 1991, JMH provided care to a population of 2 million people and an unemployment rate of 7 percent, versus the 2010 population of 2.5 million people and an unemployment rate greater than 13 percent; notwithstanding a demographics exhibiting greater diversity, an increasing aging population, and widespread migration to various areas of the County. Through the support of Ad valorem taxes, grants, charitable donations, trauma funding, and Building Better Communities General Obligation Bonds, Dr. Roldan noted, greater access of the mission was accomplished. Dr. Roldan noted that in June 2009, a new leadership team brought greater transparency to JHS' old problems of greater demand to reduce cost,

improve efficiencies and consolidate, and fewer resources. Consequently, over the past two years, she stated that JHS had focused on placing blame rather than looking for solutions, which similar entities had found.

Dr. Roldan listed flexibility, knowledge of the current markets, changing reimbursements, and streamlining of the decision-making process as features imperative to creating the change that would sustain JHS. She explained the initiatives used by the new leadership team to reduce losses of $244 million to the actual loss of $93 million—a $151 million turnaround. She added that the team was currently trending toward a loss of approximately $100 million, which was due mostly to new challenges of declining inpatient volume, reduction in funding, reduction in labor and non-labor costs; in spite of increased cash collections. Dr. Roldan stated there was a current projected loss of $400 million, including a proposed $250 million in Medicaid reductions. She stated that to balance a budget with this projected loss and break even at the end of the Fiscal Year would require elimination of much of the JHS that exists today. Dr. Roldan questioned whether JHS could afford to be everything to everyone or would it need to focus on being true to its core mission and those services it could provide with the best healthcare delivery system. She advised that JHS needed to remain viable in a competitive market with a sustainable system for the next 90 years. She emphasized the urgent need for dollars, changes in the healthcare delivery model, and rapid decision-making processes to keep JHS as it existed.

Mr. Ted Shaw, Chief Transition Officer, Jackson Health System, presented a slide show regarding JHS, reiterating comments made by Dr. Roldan and highlighting the following points:

- New challenges facing JHS;
- Year-to-date accomplishments;
- Increase in cash collections of approximately $42 million;
- Declines in volume and state funding for the indigent;
- Insufficient infrastructure;
- Gap widening between the cost of JHS' mission and available public funds;
- Economy and crisis cost approximately $200 million in 2009;
- Approximately $400 million to fulfill mission;
- Cost of mission will increase due to reduction in Medicaid;
- Cash on hand trending well; and
- Labor efficiency struggles to offset unexpected volume declines.

In conclusion, Mr. Shaw noted the challenges were still there and changes needed to be made quickly and jointly to sustain JHS. He stated the alternative to JHS not being there would not be good for the community.

Ms. Martha Baker asked Mr. Shaw to provide HGT members with a copy of the foregoing presentation.

In response to Ms. Baker's inquiry of what percentage of operational efficiencies of improvements was possible, Mr. Shaw advised that after considering labor costs, rates,

and benefits, this facility was still inefficient. He indicated a possible increase to the current 25 percent efficiency of no more than 5 percent was possible.

Dr. Steven Pinkert asked Mr. Shaw to provide HGT members with information regarding losses and efficiencies distributed over facilities and services.

In response to Dr. Kini's question regarding the decline in patient volume versus the rising unemployment rates, Mr. Shaw noted the decline was partly due to aggressive competition among hospitals to get into the Medicaid market. Additionally, he noted patients that JHS help to qualify for Medicaid tend to seek medical services elsewhere once approved. Mr. Shaw also stated the decline could also be driven by insurance companies that consider JMH a high cost provider.

Additionally, Dr. Roldan noted, regarding unemployment, the existence of an increased number of urgent care centers and the inability to capture the outpatient population also contributed to the decline in volume.

In response to Ms. Dechovitz' inquiry regarding JHS' government needs to achieve the required nimble, Mr. Shaw stated the PHT was too large and having to report to too many people, being this Board and the BCC. He suggested there be a 7 to 9 member board with the ability to make the decisions.

In response to Ms. Dechovitz' question regarding the model that would best serve JHS, Mr. Shaw stated a capital partner was necessary regardless of the model selected. He explained that it would not necessarily need to be a hospital and referenced the great partnership JHS experienced with FIU and UM, and noted their inclusion was necessary for the success of this effort.

In response to Ms. Ana Mederos' inquiry of what top ten decisions JHS would make and implement within the next 30 days, if given the authority to do so, Mr. Shaw listed the following: revisit bargaining union contracts to allow more flexibility to operate more efficiently; review the services being provided to rationalize where and what to do; seek financing partners to assist with being more nimble and capturing market share; encourage the legislature to ensure JHS received adequate funding and assignment of health plans; enlist help from public entities to join our health plan; participate in our own health plan; and ensure that the funds and materials that allow the academic programs to train and grow are sustained.

Ms. Martha Baker, as Union President of Healthcare at JHS, requested the HGT to fully understand the operations aspect before making any decisions pertaining to the hospital's governance.

Responding to Ms. Baker's comments, Dr. Donna Shalala, University of Miami President, cautioned the HGT to avoid going beyond its abilities and noted governance could help with the operations aspect. She acknowledged the validity of Ms. Baker's

point; however, she indicated focusing on operations issues too deeply would cause the HGT to go outside its assignment.

In Response to Dr. Kini's inquiry regarding what type backgrounds would be ideal for JHS, Mr. Shaw stated people with backgrounds in finance operations, leadership, and Information Technology, as well as unionized environment management.

Dr. Roldan added that the ideal mix would also include someone who had witnessed and followed the evolution of this community.

Dr. Steve Marcus requested Mr. Shaw and Dr. Roldan to provide HGT members with a financial breakdown on the entire financial state of JHS, including information for those facilities and departments that were profitable and those that were not profitable.

Ms. Mederos requested Mr. Shaw and/or Dr. Roldan to submit to HGT members a written report on recommendations they had made.

Mr. Shaw acknowledged Ms. Mederos' request and noted the JHS would present its 2012 Budget within the next 30 days with several recommendations. He advised a report would be ready for review in two weeks.

Dr. Lillian Rivera, Miami-Dade Health Department, asked Dr. Roldan, as the outgoing CEO, what she desired in terms of governance.

Dr. Roldan stated she would like this panel to look at the community as a whole to determine what was needed in Miami-Dade County. Additionally, she noted looking at the different spectrums and entities and assessing who they are in the community. Dr. Roldan further noted she desired to see a countywide healthcare delivery system, rather than only at JHS and she would like to see the layers of governance. Pertaining to Dr. Rivera's question regarding barriers to JHS' flexibility, Dr. Roldan advised that attempting to rush the system in a short timeframe without having the dollars to do so. She noted the community needed to decide whether a public healthcare system was necessary, since there were no dollars to pay for this costly issue.

In response to Dr. Pinkert's request for clarification on whether the HGT's function was to recommend for JHS being public or private or for who would govern the organization, Assistant County Attorney Shy advised that the HGT's main function was to recommend models of governance. He stated financing was a large component of governance and should be examined with regard to both public/private partnerships and governance issues. Assistant County Attorney Shy clarified his use of financing related to independent districts having statutory authority with the ability to elect a millage after going through the approval process.

Ms. Baker reiterated the importance of the operations aspects prior to addressing the governance issues. She questioned how a diagnosis of what's broken could be made without knowing the basics of where it's broken.

Ms. Dechovitz responded to Ms. Baker's comments stating the HGT needed to look at what model of governance would allow JHS to obtain the level of nimbleness desired, as well as the greatest access to money.

Dr. Shalala referenced the Grand Jury's Final Report and noted the focus was on restructuring so JHS would have access to working and a private investment gap.

Mr. Juan Carlos Zapata noted, based on Dr. Roldan's statement regarding lack of funding, the HGT should decide what type of governance structure would be able to make the imminent tough decisions of what services would be available and who would receive those services.

4. RELATIONSHIP BETWEEN UM AND JHS

Dr. Pascal J. Goldschmidt, Dean, University of Miami-Miller School of Medicine, provided a brief explanation regarding the unique relationship between the University of Miami-Miller School of Medicine (UM) and Jackson Health System (JHS). He noted the affiliation between the two entities started six (6) years ago with a basic affiliation agreement that was last updated in 2004 and an annual agreement that was revised each year. He noted the two organizations were separate entities that shared a common mission to deliver a single standard of care for everyone regardless of ability to pay. Dr. Goldschmidt explained how UM doctors were paid either by reimbursements, by Medicare payments to JMH, or by direct payment from patient insurance companies. He noted the enormous hospital approach to care was no longer valid and stated JMH should be right-sized. Pertaining to private practice issues, Dr. Goldschmidt recommended selecting activities with positive margin attraction and advised that, in a conversation with BCC Chairman Martinez, he suggested a Request for Proposal (RFP) soliciting private partners should be issued.

Dr. Roldan provided a brief summary of the relationship between JHS and Florida International University (FIU). She noted FIU's college of Medicine was currently stationed at Jackson North Medical Center. She further noted conversations were underway regarding moving FIU to Jackson Main campus; however, she noted the issue of sovereign immunity needed to be considered when attempting to locate both UM and FIU at the main campus.

Ms. Baker pointed out that this team would need to consider what options would preserve or sacrifice the sovereign immunity of FIU and UM; as well as whether goals for the legislature to broaden that aspect would be realistic.

Assistant County Attorney Karon Coleman agreed to provide a brief presentation at the next meeting regarding sovereign immunity.

Ms. Dechovitz asked that this group consider creating a list of the existing viable options in an attempt to guide the discussions.

Dr. Roldan noted she would provide, at the next meeting, reasons institutions consolidated or aligned themselves in particular partnerships and what types of partnerships they formed. Additionally, she stated she would address partnership tenures.

Mr. Larry Gage, President, National Association of Public Hospitals and Health Systems (NAPH), distributed a handout entitled "Jackson Health System Comparative Peer Group Analysis." He advised members that he would compile information regarding various models, including explanations for what and why the institutions chose their particular style of governance. Mr. Gage informed members of the necessity of this group to look at the legal powers of the PHT and noted the multiple layers of democracy could be resolved through negotiations between the PHT and the County.

5. ORGANIZATION AND STRUCTURE OF TASK FORCE

Selection of Chair and Vice Chair

Assistant County Attorney Eugene Shy opened the floor to nominations for the Chair of the Hospital Governance Task Force.

Mr. Juan Carlos Zapata declined the nomination, by Dr. Edward Feller, to serve as Chair of the HGT.

Following Ms. Baker's nomination of Mr. Jose Cancela as Chair, Mr. Cancela informed members that he served on the Public Health Trust Foundation from 1990 to 1992 and was currently a consultant, which might be a conflict of interest.

Discussion followed Mr. Cancela's acceptance of his nomination, regarding whether his serving as a consultant to the PHT Foundation constituted a conflict of interest. Upon HGT members' determination that a conflict of interest issue existed, Mr. Cancela withdrew his acceptance and declined the nomination.

Ms. Amy Perry noted, although Ms. Linda Quick was absent, Ms. Quick would be a good choice as chair, due to her vast experience and suggested she be nominated.

Dr. Keeley nominated Ms. Linda Quick to serve as Chair of the HGT.

Mr. Cancela asked Mr. Zapata to reconsider accepting the earlier nomination to serve as Chair, which Mr. Zapata accepted.

Hearing no further nominations, Assistant County Attorney Shy closed the floor to nominations for Chair with the two candidates.

Ms. Smith-York, Clerk, announced the ballot results were as follows: Ms. Linda Quick received two (2) votes and Mr. Juan Carlos Zapata received 14. She noted, for the record, that Mr. Juan Carlos Zapata was selected as Chair of the Hospital Governance Task Force.

Chair Zapata opened the floor to nominations for Vice Chair.

Dr. Shalala nominated Ms. Susan Dechovitz to serve as Vice Chair, and upon hearing no further nominations, the floor was closed to nominations.

Chair Zapata announced that, since there were no other nominations, Ms. Susan Dechovitz was selected as the Vice Chair.

Selection of Additional HGT member

It was moved by Dr. Edward Feller, that the selection of additional HGT members be deferred to the next meeting. This motion was seconded by Mr. Cancela, and upon being put to a vote, passed by a unanimous vote of those members present.

Meeting Schedules

Following discussion among members regarding the best time and location for future meetings, the HGT decided to convene every Thursday of each week at 3:00 p.m., for the next 90 days, beginning April 7, 2011. The location would remain at the Beacon Council Offices, 80 SW 8th Street, Suite 2400, Miami, Florida, unless that site was unavailable, at which time an alternate location would be advised.

Decision – Who Should Write Final Recommendations for BCC

Discussion ensued among members regarding the final recommendations and the need for strict adherence to the Sunshine Law throughout the development of said recommendations.

6. OTHER MATTERS

Dr. Shalala asked staff to provide HGT members with a listing of the future meetings.

7. ADJOURNMENT:

There being no further discussion, the Hospital Governance Task Force meeting was adjourned at 11:52 a.m.

Juan C. Zapata, Chairperson
Miami-Dade Hospital Governance Task Force

SUMMARY AND OFFICIAL MINUTES
SUNSHINE MEETING
MIAMI-DADE COUNTY HOSPITAL GOVERNANCE TASKFORCE
APRIL 5, 2011

The Miami-Dade County Hospital Governance Taskforce (HGT) Sunshine meeting was held at the Office of the President of the University of Miami (UM), 1252 Memorial Drive, Ashe Building, Room 230, Coral Gables, Florida, on April 5, 2011 at 3:00 p.m., there being present: Chair Juan C. Zapata, Vice-Chair Susan Dechovitz, and Members Martha Baker, Ed Feller, Robert Johnson, Brian Keeley, Linda Quick, Steven Marcus, and Donna Shalala.

Others present were: Dan Ricker, Watchdog Report; Joaquin del Cueto, Public Health Trust; University of Miami representatives J.C. Del Valle, Jackie Menendez, Bill Donelan, and Joe Arriola; Stacy Kilroy, Mount Sinai Medical Center; Paul Silverman, State Attorney's Office; and Lorraine Nelson, Jackson Health System Public Relations

The following staff members were present: Assistant County Attorneys Eugene Shy, Laura Llorente, and Valda Christian; Janet Perkins, Director, Office of Countywide Healthcare Planning; Ruben J. Arias, County Commission District 7; Marcos San Martin, County Commission District 6; Gary Collins and S. Donna Palmer, Office of the Commission Auditor.

Chair Zapata called the meeting to order at 3:11 p.m. and noted the purpose of the meeting was to review and organize the materials presented on hospital governance in preparation for the HGT meeting on Thursday, March 7, 2011.

The items for discussion were:

1. Setting parameters as criterion/principles
2. Revising the Hospital Governance Change Cross-Referenced Matrix prepared by staff

Dr. Feller expressed the need for a criterion/principles list to determine how the governance structure should be created. The following members offered items to be added to the list - Chair Zapata, Vice Chair Dechovitz, Martha Baker, Ed Feller, Robert Johnson, Linda Quick, and Donna Shalala. Mr. Robert Johnson offered to work with staff to compile a combined list of criterion/principles for discussions at the taskforce meeting scheduled for Thursday, April 7, 2011. The objective of the taskforce will be to rank the criterion/principles based on priority.

Discussions ensued among members on ways to revise the Hospital Governance Change Cross-Referenced Matrix. It was suggested that a comprehensive matrix with additional columns on related characteristics should be added. A governance models handout from Ms. Linda Quick was also discussed. Ms. Quick offered to work with staff to incorporate the information from her handout into the cross-referenced matrix. It was suggested that the following five (5) hospital models be included in the revised matrix – Detroit, Cook County, Parkland, Philadelphia and LA County. Chair Zapata noted

that the revised matrix would be presented at the next meeting to determine the top models for consideration. He added that after the top models were selected, CEOs and/or trust members, familiar with those models, would be invited to make presentations at future taskforce meetings.

Having concluded discussions on the criterion/principles list and cross–referenced matrix, the meeting was adjourned at 4:52 p.m.

Juan C. Zapata, Chair

FINAL OFFICIAL MEETING MINUTES
Miami-Dade County Hospital Governance Taskforce (HGT)

Beacon Council Office Facility
80 S.W. Eighth Street, Suite 2400
Miami, Florida 33130

April 7, 2011
As Advertised

Harvey Ruvin, Clerk
Board of County Commissioners

Diane Collins, Acting Division Chief
Clerk of the Board Division

Mary Smith-York, Commission Reporter
(305) 375-1598

CLERK'S FINAL OFFICIAL MEETING MINUTES
MIAMI-DADE COUNTY HOSPITAL GOVERNANCE TASKFORCE
APRIL 7, 2011

The Miami-Dade County Hospital Governance Taskforce (HGT) convened a meeting at the Offices of The Beacon Council, 80 S.W. 8th Street, Suite 2400, Miami, Florida, on Thursday, April 7, 2011, at 3:00 p.m., there being present Chairperson Juan Carlos Zapata, Vice Chairperson Susan Dechovitz, and Members: Martha Baker, Jose Cancela, Ed Feller, M. Narendra Kini, Marisel Losa, Steven Marcus, Ana Mederos, Linda Quick, Sharon Pontious, Lillian Rivera, Donna Shalala, Alternate member Amy Perry representing Steven Sonenreich, and George Foyo representing Brian Keeley, (Members Manuel P. Anton III, Lee Chaykin, Brian Keeley, Steven Pinkert, and Steven Sonenreich were absent).

I. ROLL CALL:
The following staff members were present: Assistant County Attorneys Valda Clark Christian, Karon Coleman, and Laura Llorente; Gary Collins, S. Donna Palmer, and Noel Aranha, Office of Commission Auditor; and Deputy Clerk Mary Smith-York.

Chairman Juan Zapata called the meeting to order at 3:10 p.m.

II. APPROVAL OF MINUTES
The following corrections to the March 28, 2011, minutes were requested:

- page 5, last sentence, change the word "needed" to "possible;"
- page 6, 3rd paragraph from bottom, line 2, after language "...30 days..." add the phrase "if given the authority to do so;
- page 7, insert the following language as paragraph 3: "Dr. Steve Marcus requested Mr. Shaw and Dr. Roldan to provide HGT members with a financial breakdown on the entire financial state of JHS, including information for those facilities and departments that were profitable and those that were not profitable;"
- page 10, correct language under the heading "Decision-Who Should Write Final Recommendations for BCC," to reflect no determination as the entire HGT would perform that task; and
- page 7, paragraph 3, delete "the Jackson Foundation" and insert "recommendations they had made."

It was moved by Dr. Feller that the March 28, 2011, meeting minutes be approved as amended with the foregoing changes. This motion was seconded by Ms. Mederos, and upon being put to a vote, passed unanimously by those members present.

III. OPENING REMARKS
Chairperson Zapata announced that Mr. Robert Johnson was the new designee from Nation Association of Public Hospitals and Health Systems, replacing Mr. Larry Gage. He summarized the purpose of the Sunshine Meeting held Tuesday, April 5, 2011, and highlighted the following points: developing questions from draft criterion/principles; brainstorming issues for inclusion in the final recommendation; reviewing matrix developed by Gary Collins and Linda Baker comparing various governance structures.

Chairperson Zapata provided a brief overview of conversations he had with the Governor's office and representatives of other entities relevant to hospital governance regarding Jackson Health System (JHS) and the Public Health Trust (PHT). Chairman Zapata noted he asked staff to prepare a report reflecting amounts and percentages based on growth rates and revenues on low compensated care in Miami-Dade County, and a list of PHT decisions that required County Commission approval.

IV. ACTION ITEM

A. Selection of New Member

It was moved by Dr. Shalala that Dr. Michael Barron be selected as the new member representing the Medical Executive Committee of Jackson Memorial Hospital. This motion was seconded by Dr. Feller, and upon being put to a vote, passed unanimously by those members present.

V. PRESENTATIONS

A. Mr. Larry Gage, President, NAPH

Mr. Gage provided a PowerPoint presentation entitled Models for Organizations & Structural Reform and highlighted the following points:

- What is a typical public hospital?
- Why do public hospitals restructure?
- Case Studies of structural reforms

Mr. Gage concluded his presentation by listing issues to be considered and invited members to ask any questions they might have.

Dr. Shalala asked Mr. Gage to identify alternatives for academic health centers.

A question and answer session ensued among HGT members and Mr. Gage, regarding what Mr. Gage would recommend for the existing structure at JHS, what governance issues drove the health centers to restructure, what type of community outreach were the majority of hospitals looking into, what amount of outsourcing was occurring in smaller hospitals

Vice Chairperson Dechovitz suggested the HGT finalize its list of criterion on non-negotiable issues for implementation within the JHS, and submit that list to Mr. Gage for further tweaking and identifying governance models that would be realistic for this system.

B. Ms. Karon Coleman, Assistant County Attorney

Ms. Coleman advised Hospital Governance Task Force members that if they had not yet submitted a financial disclosure form, they should not do so. She noted the Commission on Ethics and Public Trust, in conjunction with the County Attorney's Office, had determined that it was not necessary to make a filing, and forms would be returned to those who had filed.

C. Mr. Jorge L. Arrizurieta, Trustee, Public Health Trust

Mr. Arrizurieta appeared before the HGT and introduced fellow Trustees, Mr. Martin Zilber and Mr. Joaqun del Cueto. Mr. Arrizurieta provided a brief overview of the PHT and the need for a change in its governance structure. He highlighted four areas that needed to be addressed: 1) budget process, 2) unfunded or under-funded mandates, 3) employment costs, and 4) overhaul of the University of Miami/Jackson Health System and the Florida International University/Jackson Health System relationships. In response to Chairperson Zapata's inquiry of a recommended model, Mr. Arrizurieta indicated his personal recommendation would be the Tampa model. He noted Grady Health Center in Atlanta, Georgia, was his recommendation for outside of the Florida area.

Following discussion, HGT members agreed to invite representatives from the following medical centers to make presentations at the next meeting: 1) Truman, 2) Cook County, 3) Harborview/UW, 4) Boston, and 5) LA County.

Chairperson Zapata explained that, although the representatives from the aforementioned medical centers would be invited to present at next Thursday's meeting, written reports should be prepared for the entire list of centers, including Tampa, Grady, Truman, Denver, Cook, Palm Beach, Boston, LA County, and Harborview/UW.

Discussion ensued regarding the timeframe necessary to prepare questions for the presenters, how the questions would be prepared, who would present the questions to the presenters, and whether the presentation should be in person or teleconferenced. Members agreed to format the existing criterion/principles into questions and submit them to the Commission Auditor's staff, who would work with Ms. Linda Quick to organize them.

Assistant County Attorney Karon Coleman advised members to submit any comments they had on the questions to Ms. S. Donna Palmer in the Office of the Commission Auditor for placement on the Website.

In response to Dr. Shalala's suggestion that individual members submit questions to Ms. Palmer for placement on the web, Mr. Gary Collins suggested members email input to Ms. Palmer, for organizing and placement on the web.

Chairperson Zapata advised that the remaining items on today's agenda would be discussed at the next meeting. He advised that the next meeting (4/14) would be held at the State Attorney's Office and the following meeting on the 21st would be held at the Beacon Council facility.

Members scheduled a Sunshine Meeting on Monday, April 11, 2011 from 4:00 p.m. – 5:00 p.m. at the State Attorney's Office located at 1350 NW 12th Avenue, 4th Floor Conference Room, to finalize interview questions.

VI. DISCUSSION ITEMS
Deferred to April 14, 2011

VII. OTHER MATTERS
Deferred to April 14, 2011

VIII. ADJOURNMENT:
There being no further business to come before the HGT, the meeting adjourned at 6:12 p.m.

Juan C. Zapata, Chairperson
Miami-Dade Hospital Governance Task Force

SUMMARY AND OFFICIAL MINUTES
SUNSHINE MEETING
MIAMI-DADE COUNTY HOSPITAL GOVERNANCE TASKFORCE
APRIL 11, 2011

The Miami-Dade County Hospital Governance Taskforce (HGT) Sunshine meeting was held at the State Attorney's Office, 1350 NW 12th Avenue, 4th Floor Conference Room at 4:00 p.m., there being present: Members Martha Baker, Robert Johnson, Lillian Rivera, Donna Shalala, and Alternate member Jaime Caldwell representing Linda Quick.

Others present were: Paul Silverman, State Attorney's Office; Lorraine Nelson, Jackson Health System Public Relations; and Joaquin del Cueto, Public Health Trust

The following staff members were present: Assistant County Attorneys Valda Christian and Laura Llorente; and Gary Collins and S. Donna Palmer, Office of the Commission Auditor.

Member Donna Shalala called the meeting to order at 4:04 p.m. The purpose of meeting was to discuss and finalize the list of suggested questions for other hospitals/health systems leadership, for the teleconference interview scheduled for Thursday, April 14, 2011.

Discussion ensued among members and the following suggestions were made:

1. Staff should prepare a FACT sheet on the hospitals/health systems to be interviewed.
2. Five (5) structure questions will be selected for use during the interviews.
3. The selected interview questions should be sent to the interviewees prior to the meeting.

Having concluded discussions on the interview questions, the meeting was adjourned at 4:55 p.m.

Donna Shalala

FINAL OFFICIAL MEETING MINUTES
Miami-Dade County Hospital Governance Taskforce (HGT)

State Attorney's Office
1350 NW 12th Avenue
4th Floor Conference Room
Miami, Florida

April 14, 2011
As Advertised

Harvey Ruvin, Clerk
Board of County Commissioners

Diane Collins, Acting Division Chief
Clerk of the Board Division

Mary Smith-York, Commission Reporter
(305) 375-1598

CLERK'S FINAL OFFICIAL MEETING MINUTES
MIAMI-DADE COUNTY HOSPITAL GOVERNANCE TASKFORCE
APRIL 14, 2011

The Miami-Dade County Hospital Governance Taskforce (HGT) convened a meeting at the Offices of The Beacon Council, 80 S.W. 8th Street, Suite 2400, Miami, Florida, on Thursday, April 14, 2011, at 3:00 p.m., there being present Chairperson Juan Carlos Zapata, Vice Chairperson Susan Dechovitz, and Members: Manuel P. Anton III, Dr. Michael Barron, Martha Baker, Ed Feller, Brian Keeley, Marisel Losa, Linda Quick, Steven Pinkert, Sharon Pontious, Lillian Rivera, Donna Shalala, Steven Sonenreich, (Members Jose Cancela, Lee Chaykin, Robert Johnson, M. Narendra Kini, Steven Marcus, and Ana Mederos were absent).

I. ROLL CALL:
The following staff members were present: Assistant County Attorneys Karon Coleman and Laura Llorente; Charles Anderson, S. Donna Palmer, Angie Martinez, and Noel Aranha, Office of Commission Auditor; and Deputy Clerk Mary Smith-York.

Chairman Juan Zapata called the meeting to order at 3:02 p.m.

II. OPENING REMARKS:
Chairperson Juan C. Zapata advised members that he had placed additional items on today's (4/14) agenda. He invited HGT members to also place items pertaining to governance and the efforts of this Task Force on the agenda by submitting the information to Ms. Palmer in the Commission Auditor's Office. Mr. Zapata suggested that members look at "The Privatization of Public Hospitals" article on the Website and review the various processes and procedures used by hospitals.

Mr. Zapata reminded members of the need to determine the type of recommendations they would make to the County Commission, and noted he would like the Task Force to ratify its submission at the May 12, 2011 HGT meeting. He expressed his preference to propose several options for the County Commission to consider; however, the Task Force could decide to present one option or multiple scenarios.

III. PRESENTATIONS

A. The Sibery Group, LLC
Mr. Duane Fitch, Senior Partner and Chief Financial Officer, The Sibery Group, LLC, appeared before the Task Force and provided a brief historical overview and introduction of The Sibery Group organization. He presented a PowerPoint presentation covering the following topics: Importance of Taskforce; Immediate Issues Independent of Governance Discussion; Current Governance Model; Governance Effectiveness vs. Governance Structure; Operational Issues Universal to All Governance Models; PHT Observation; and Miami-Dade County Observation. Mr. Fitch emphasized the importance of a governance dashboard to be in place.

Dr. Edward Feller concurred with Mr. Fitch's point regarding the Public Health Trust (PHT) board members' lack of experience in hospitals, management, healthcare, and finances. He also agreed that the political influence of the Board of County Commissioners was detrimental to the success of the hospital board.

IV. TELECONFERENCE INTERVIEWS

A. Boston Medical Center

Mr. Tom Traylor, Vice President of State, Local, and Federal Programs, Boston Medical Center, briefly highlighted his credentials, followed by a historical overview of the legal structure, governance, and mission of the Boston Medical Center (BMC) via teleconference. Referencing the information included in today's agenda package that he provided prior to this meeting, Mr. Traylor discussed the hospital's financial background, affiliations, and composition of the Board of Trustees. He indicated the reason BMC created a change in its governance structure was to address the hospital's limited ability to be flexible and competitive, due to being part the City.

Mr. Traylor provided the following responses to questions presented by HGT members Lillian Rivera, Martha Baker, and Donna Shalala:

1. How did your change in governance lead to improved patient care, increased patient satisfaction, and increased market share and revenue? Any impact on access to healthcare services?

Improvement in quality, growth in volume, ability to improve additional conditions, and growth in market share (20,000 admissions to 30,000); still challenged in patient satisfaction rate; overall growth in revenue, notwithstanding current challenges due to the Massachusetts Healthcare Reform changes.

2. What turnaround efforts did your hospital/health system go through before consideration of governance changes? Describe the success or lack thereof of these efforts and why?

Motivation for governance change was to gain flexibility in terms of having the ability to retain own revenue, as a typical business versus the government being on a cash basis, with the ability to invest and add more revenue.

There was a simultaneous governance structure and merger, in which the private hospital had much more of a Medicare payer mix and the DCH had a typical Medicaid pre-care mix, and when they were combined, the absolute safety net hospital became more diversified with more commercial or Medicare mix than a typical safety net hospital. Overall, the combined system grew and the payer mix was still at about 30 percent Medicaid and still 10 percent uninsured, even with Massachusetts Healthcare Reform. Over half the patients were low-income patients.

3. What impact did the governance change have on your mission and how is that measured?

The Chief of Medicine was on both sides of the street so already shared combined medical services, which helped get through problems with other mergers. Overall, a plus on both quality and teaching programs to have everything combined. City Hospital was originally at 10 percent Medicaid or mix, but with the combined hospitals together, it was approximately 30 percent Medicare.

4. How did the old governance structure evaluate its effectiveness? How does the new governance structure do the same?

Under the old structure, the hospital was basically run by the City and evaluated through annual budget reviews; currently, a 30-member Board, consisting of various subcommittees (Finance, Audit, Nominating), evaluates its performance in governance, as well as the effectiveness of the hospital's performance team, including the Chief Executive Officer (CEO). One annual meeting was mandated and statute requirements that BMC remains true to the historic mission as a safety net hospital. There was no actual scorecard for measuring effectiveness. The 30-member Board was manageable with generally 20-25 attendees at bi-monthly meetings; staffing being relatively small.

5. What was the direct correlation between the change in governance and improved financial viability? Could the same result have been achieved under the existing governance structure? Why or Why not?

Either the governance change and/or the merger or both in combination worked to make BMC significantly better, finically stronger and larger, and a stronger hospital than City Hospital alone was, by all measures. The same results could not have been achieved under the existing governance structure.

The current governance structure assumed complete authority over the personnel system and legal processes.

Mr. Traylor noted the Strong Mayor observed other hospitals in Boston merging and championed this merger as being better for Boston City Hospital. Some individual City Council members expressed opposition; however, the Boston Health Net Centers supported this merger as a way to have a stronger safety net hospital.

Mr. Traylor noted that the hospital's budget was approximately $1 billion with approximately $100 million un-reimbursed cost and approximately $200 million un-reimbursed Medicaid cost. Admissions had been paid in various ways, largely by the Federal Government by Medicaid waivers. The State of Massachusetts maintained a Safety Net Pool that paid hospitals for the remaining uninsured which provides a revenue stream for BMC. During the current year, BMC lost approximately $25 million of the $1 billion budget and anticipated the same lost for FY 2010-11. BMC's market share within Boston had grown slightly since the merger; however, so had most of the other teaching

hospitals in Boston. The Boston Health Net's governance was separate from the BMC Board; the members were Boston Medical Center, Boston University Medical School, and 15 Health Centers. The Boston Health Net Centers were Federally Qualified Health Centers and teaching was conducted at those centers.

Regarding labor opposition to merger, Mr. Traylor stated some pre-agreements protecting pensions and other benefits allowed the merger to go forward. The same unions were retained in the merger, including two separate nursing unions from the two predecessor hospitals. Composition of the 30-member Board as representation of the mission and the enabling legislation and state statute were instrumental in addressing the labor issues.

B. Harborview Medical Center

Ms. Johnese Spisso, Chief Health Systems Officer, Harborview Medical Center (HMC), provided an extensive historical overview of the HMC via teleconference. Following this presentation, she gave the following responses to questions from HGT members Lillian Rivera, Martha Baker, and Donna Shalala:

1. How did your change in governance lead to improved patient care, increased patient satisfaction, and increased market share and revenue? Any impact on access to healthcare services?

Using the intellectual, capital, and talent of University of Washington and world class UW physicians to staff the medical centers. Two large medical centers in close proximity to UW, compete for paying patients. Among the 50th percentile in patient satisfaction rating. UW Medical Center and Medical School were owned by the State and Harborview was owned by the County and managed by the UW.

2. What turnaround efforts did your hospital/health system go through before consideration of governance changes? Describe the success or lack thereof of these efforts and why?

Harborview was struggling financially and with quality of care in 1970, which led to consideration of governance change.

3. What impact did the governance change have on your mission and how is that measured?

All physicians employed at Harborview are members of UW Physicians; however, the community physicians from throughout the region, refer physicians.

4. How did the old governance structure evaluate its effectiveness? How does the new governance structure do the same?

Governance consists of: a 13-member Board of Trustees governs the medical center and is responsible for fiduciary matters, conducts annual evaluation of its performance, produces an annual priority report to the Board and the community; an Executive

Director employed by UW, who reports to Chief Health System Officer and the Board of Trustees; and a UW Medicine Board. Trustees serve three consecutive three-year terms.

Regarding bond issue, a major institutional master plan is updated every ten years and decisions are made with the Board to do expansions or upgrades, and following approval by the County Council a bond initiative can be issued. The State went to collective bargaining approximately six years ago and prior to that there were civil service contracts. Currently five labor unions existed throughout their health system and the contracts were negotiated through UW Human Relations and Labor Relations. There were no longer any civil service contracts. UW Medicine Advancement Office by which employees does fundraising for every aspect of their system, which collects approximately $6 million per year to support quality unfunded care.

Harborview does not receive compensation from the County to provide jail health services. The UW complies with the state Sunshine Act which presents a challenge at times, but has not hurt the hospital's ability to function.

V. DISCUSSION ITEMS

A. Resignation Letter from Dr. Mark C. Rogers

B. Juniper Advisory – Firm Overview

VI. OTHER MATTERS

Chairperson Zapata requested feedback from Task Force members regarding how to move forward with development of the recommendations. He asked the Commission Auditor's staff to provide ideas on how to structure the final recommendations, and based on that, the HGT could submit their ideas. In response to Mr. Zapata's inquiry of who would write the actual document, Commission Auditor Charles Anderson informed that staff member Gary Collins would be responsible for writing the recommendation document.

Chairperson Zapata expressed concern with individual members providing information to members of the media, and it was the consensus of the Task Force that the media obtain its information by attending meetings and/or accessing the HGT Website.

Dr. Shalala recommended development of the recommendations should begin with the concept reflected on the Working Draft, A. Governing Board and Organizational Characteristics, 2. A governance model that provides clear lines of accountability for the governing body to the County government and the public/Strong ethical and conflict of interest component.

Vice Chairperson concurred with Dr. Shalala's comment that everything should flow from No. 2, however, she added that something should mention "the Safety Net Mission."

Chairperson Zapata indicated that the Mission Statement should be separate and that the governance structure was basically whatever body would oversee Jackson

Hospital/Health System. He emphasized the need for that structure to have independence, and referred to the list of the 14 issues that require the County Commission's approval.

Regarding the Working Draft (List of Recommendations), members agreed to consolidate numbers 3 and 8, to modify number 5 to eliminate the first three to read "Modification to the Sunshine Laws, which allows for maintenance of a sustainable vision."

Discussion ensued regarding whether size of the Board of Trustees makes a difference. Dr. Keeley advised that the ideal Board consisted of smart people who understood healthcare organizations, i.e. business people, finance people, bankers, lawyers, etc. Following discussion, HGT members agreed that the Board should consist of no more than nine members.

HGT members asked staff to provide information regarding how the Boards of some of the organizations of interest were populated, how members were nominated/appointed, what skills were required, and what the public's role was in this process. Staff was also asked to research what types of outside entities or transition models were created to oversee that Board and the hospital's functions to ensure it stayed true to its mission.

Chairperson Zapata advised that the next meeting would be held on Thursday, April 21, 2011, at the Beacon Council Office, 80 S.W. 8th Street, Suite 2400.

VII. ADJOURNMENT

There being no further business to come before the HGT, the meeting adjourned at 5:57 p.m.

Juan C. Zapata, Chairperson
Miami-Dade Hospital Governance Task Force

FINAL OFFICIAL MEETING MINUTES
Miami-Dade County Hospital Governance Taskforce (HGT)

Beacon Council Offices
80 S.W. 8th Street, Suite 2400
Miami, Florida

April 21, 2011
As Advertised

Harvey Ruvin, Clerk
Board of County Commissioners

Diane Collins, Acting Division Chief
Clerk of the Board Division

Mary Smith-York, Commission Reporter
(305) 375-1598

CLERK'S FINAL OFFICIAL MEETING MINUTES
MIAMI-DADE COUNTY HOSPITAL GOVERNANCE TASKFORCE
APRIL 21, 2011

The Miami-Dade County Hospital Governance Taskforce (HGT) convened a meeting at the Offices of The Beacon Council, 80 S.W. 8th Street, Suite 2400, Miami, Florida, on Thursday, April 21, 2011, at 3:00 p.m., there being present Chairperson Juan Carlos Zapata and Members: Martha Baker, Michael Barron, Jose Cancela, Ed Feller, Robert Johnson, M. Narendra Kini, Marisel Losa, Steven Marcus, Ana Mederos, Steven Pinkert, Linda Quick, Sharon Pontious, Lillian Rivera, Donna Shalala, Steven Sonenreich, and Alternate member George Foyo representing Brian Keeley; (Vice Chairperson Susan Dechovitz and Members Manuel P. Anton III, Lee Chaykin, and Brian Keeley were absent).

I. ROLL CALL:
The following staff members were present: Assistant County Attorneys Eugene Shy, Karon Coleman, and Laura Llorente; Gary Collins, S. Donna Palmer, and Antonio Crawford, Office of Commission Auditor; and Deputy Clerk Mary Smith-York.

Chairman Juan Zapata called the meeting to order at 3:10 p.m.

II. OPENING REMARKS
Chairperson Zapata referenced points from last weeks meeting and addressed the issue of the Board of County Commissioners (BCC) proposing the establishment of a seven-member board to oversee the Public Health Trust. Pursuant to his concerns of how the seven-member board would impact the work of the HGT, Mr. Zapata, in speaking with County Commission Chair Joe Martinez, understood this to be a temporary measure.

Assistant County Attorney Karon Coleman advised that the subject board was the Financial Recovery Board (FRB), that it was in place for a period of 24 months pursuant to resolution by the BCC, and that it would not lead to overall governance.

In response to Mr. Cancela's question of whether there was an item on the BCC agenda providing that the ordinance be amended to stipulate that a 2/3 vote could overturn the seven-member board, Assistant County Attorney Karon Coleman explained that there were two potentials: that an amendment to the ordinance to put 2/3 vote in the 25A language; and, in the resolution that would establish the FRB.

Dr. Pinkert suggested Public Health Trust members should be heard and recommended former Trustee Dr. Mark Rogers, followed by other past and present PHT and BCC members, be asked to make presentations. Dr. Pinker explained this would allow the HGT to attest that its recommendations were evidence-based.

Discussion ensued among members regarding presentations done by PHT and BCC members versus representatives of healthcare centers that had undergone governance change, and experts' opinions versus evidence-based recommendations.

Dr. Shalala pointed out that the presentations given thus far all said their governance change made them more competitive and provided them flexibility and control over the most important elements in management, including contracts and personnel. She emphasized the point that the driving force behind most of the changes in governance was independence, the ability to make tough decisions in a competitive market.

Ms. Baker suggested there be a debriefing session following each presentation to identify points that addressed key problems being targeted by the HGT, i.e. smaller board size.

Chairperson Zapata advised that he met with the Dr. Eneida Roldan, Chief Executive Officer, JMH, and spoke with BCC Chairman Joe Martinez regarding the HGT's working draft document. He highlighted several components of the case study done on four hospitals reflected in the Kaiser Study of 1999, including operational, labor unions, political, accountability, etc. that would be helpful to the efforts of the HGT. Chairperson Zapata noted he was receptive to Dr. Rogers making a presentation, but pointed out that the HGT must reach a consensus on the type of recommendations it wished to present to the BCC. He stressed the importance of putting some ideas together as a foundation.

Dr. Sonenreich suggested the HGT consider looking at the Center for Healthcare Governance (CHG), an institution that provided information and resources to hospitals' boards. He recommended Dr. James E. Orlikoff, Senior Consultant, be contacted for direction regarding governance issues.

Ms. Quick volunteered to invite Dr. John Combes, President and Chief Operating Officer at the CHG in Chicago, IL, to participate in a teleconference presentation at the next HGT meeting.

Chairperson Zapata requested Commission Auditor representative Donna Palmer to coordinate presentations by Dr. Combes and Mr. Carlos Migoya, President Elect, Jackson Memorial Hospital, for the HGT meeting on April 28, 2011.

Dr. Feller urged the HGT to move quickly in amassing and analyzing the Task Force members' opinions to determine whether therein lay a quick answer.

III. APPROVAL OF MINUTES (April 7, 2011)

The following corrections to the April 7, 2011, minutes were requested:

- On page 3, paragraph 2, include "L.A. County" in the list of medical centers.

It was moved by Dr. Kini that the April 7, 2011, meeting minutes be approved as amended with the foregoing requested change. This motion was seconded by Dr. Shalala, and upon being put to a vote, passed by a unanimous vote of those members present.

IV. TELECONFERENCE INTERVIEWS

A. Cook County Health & Hospitals System

Ms. Elizabeth Reidy, General Counsel, Cook County Health & Hospital System, Chicago, IL, greeted HGT members and explained that she was representing Chief Executive Officer William Foley and Board Chairperson Warren Batts, who were unable to participate due to schedule conflicts. She advised that her responses would be limited due to her role as General Counsel, as opposed to Director/CEO. Ms. Reidy advised that a second brief call that included the CEO or Chairperson was recommended in order to answer in depth questions. She provided a brief introduction and historical background regarding Cook County Bureau of Health Services, renamed Cook County Health & Hospital System (CCHHS) in its governance change process.

Following Ms. Reidy's overview, she provided the following responses to the HGT's questions presented by Drs. Barron, Kini, and Pontious:

1. How did your change in governance lead to improved patient care, increased patient satisfaction, and increased market share and revenue? Any impact on access to healthcare services?

The CCHHS Board consisted of eleven directors, ten of which are healthcare oriented and one an ex-officio member, who was Chairman of the CCHHS Commission. The CEO looked at staffing issues, hired experts in performance improvements and did significant staff reductions, which included vacant and filled positions. Specific governance-related questions should be made to the Director for a more appropriate response. The turnaround expert was guided by a core of professionals who knew about the health industry. Key issue was reimbursement and whether the dollars owed were being captured and the governance and policy experts began working from that perspective as soon as possible.

2. What turnaround efforts did your hospital/health system go through before consideration of governance changes? Describe the success or lack thereof of these efforts and why?

The hospital went from being governed on a direct hands-on basis by elected officials to being governed at a Board level by a group of experts. Brought the centralized human resources and purchasing functions in-house. The Board consisted of one director who was head of another hospital, and two other members were from neighboring hospitals.

3. What impact did the governance change have on your mission and how is that measured?

The mission has remained unchanged. One of the largest projects of board was to manage a five-plan entitled "Strategic Plan Vision 2016" which entailed a significant reallocation of resources to the system. Trying to reallocate limited resources to focus on outpatient specialty care, primary care, and immediate care.

4. How did the old governance structure evaluate its effectiveness? How does the new governance structure do the same?

New governance structure evaluates effectiveness through an Operational Ops (phonetic) Plan for benchmarking, as well as traditional red light, yellow light, green light system, and performance improvement benchmarking.

5. What was the direct correlation between the change in governance and improved financial viability? Could the same result have been achieved under the existing governance structure? Why or Why not?

Ms. Reidy advised that she was unable to answer the foregoing question. She stated the Board of Directors approved bargaining agreements, but the County Board of Commissioners negotiated them. She advised she was not sure as to whether they were civil or healthcare service. Ms. Reidy was also unable to answer the question regarding what percentage of the $630 million total healthcare revenues came from outpatient clinics. Ms. Reidy asked that the HGT provide her with a copy of its final report once completed.

Discussion ensued among members highlighting the differences between the Cook County Board and the PHT, including the smaller size and the objective of strategic planning and personnel issues.

Regarding the issue of "conflict of interest" among board members, Chairperson Zapata advised that he was awaiting a response from the Ethics Commission and the Inspector General regarding this subject. He stated he would recommend creating a system that incorporated an open setting wherein the CEO could communicate with the governing body.

B. L.A. County Department of Health Services

Mr. John Schunhoff, Chief Deputy Director, Los Angeles County Department of Health Services (LACDHS), provided the following responses to questions by Drs. Barron, Kini, and Pontious:

1. How did your change in governance lead to improved patient care, increased patient satisfaction, and increased market share and revenue? Any impact on access to healthcare services?

The governance structure was described as a department of the County of Los Angeles, governed by the five members of the Board of Supervisors, who were County Commissioners. There was uncertainty as to whether a direct link existed between the change in governance and the strides they made in terms of patient care and finance. California law gives counties responsibility for providing indigent care. The majority of the counties did not operate public hospitals and clinics, rather contracted those services to private hospitals and community clinics. LA County has a history of having public hospitals and clinics and provides indigent care through its facilities; and in the past 15

years, funding has been provided to the LA County Community Clinics to provide indigent primary care, while the hospital provided more specialty care.

2. What turnaround efforts did your hospital/health system go through before consideration of governance changes? Describe the success or lack thereof of these efforts and why?

There was significant increase in the number of patients coming to the emergency rooms and some of this increase was attributed to a change to one of the facilities. The system recently opened the L.A. County Medical Center that was a 600-bed facility. Pursuing a different model of governance relative to the new Martin Luther King Hospital scheduled to open in 2013. Rather than opening a new County Hospital, a county facility was being built, whereby the LACDHS and the University of California (UC) jointly formed a non-profit corporation that would contract with the County to lease the facility and operate the hospital. The UC would provide the medical oversight and quality oversight board with regard to the core physician services. This was a different approach compared to the other four hospitals in the system that were County-owned and operated.

3. What impact did the governance change have on your mission and how is that measured?

The Board of Supervisors had a strong commitment to low-income and indigent care and over the years put significant amounts of County dollars into the health care system. This Board has essentially taken off the Department of Health Services from the general fund problems, particularly those related to the extension. There were three types of budgets in the County: the general fund, special districts, and health department. Have not had to encounter the same source of reductions that the general fund departments had.

4. How did the old governance structure evaluate its effectiveness? How does the new governance structure do the same?

Each facility measures quality of care by objective measures; periodically, the chiefs meet with the medical staff to go over issues. Unsure whether there was a systematic method of measuring effectiveness and have not evaluated the role of the Board in governing the health system.

5. What was the direct correlation between the change in governance and improved financial viability? Could the same result have been achieved under the existing governance structure? Why or Why not?

The governance structure has not had an impact on the financial viability of the health system; however, with the new County governance structure has cross collaboration and communication. This was evidenced in the health services to juveniles through the Probation Department and the department of Children and Family Services, having to report to the Board through the CEO.

D. Truman Medical Centers

Mr. Gerard Grimaldi, Vice President, Health, Policy & Government Relations, Truman Medical Centers (TMC), introduced Chief of Staff Cheryl Washington, and President/CEO John Bluford. Following a brief historical overview of the organization's governance structure, he provided the following responses to questions prepared by the HGT members:

1. How did your change in governance lead to improved patient care, increased patient satisfaction, and increased market share and revenue? Any impact on access to healthcare services?

A key governance problem was addressed by the downsizing the Board from 50 members. TMC was a 501(C)3 organization and the City and County each had three members on the Board of Directors.

2. What turnaround efforts did your hospital/health system go through before consideration of governance changes? Describe the success or lack thereof of these efforts and why?

3. What impact did the governance change have on your mission and how is that measured?

The governance has allowed the operational structure to be innovative and entrepreneurial in terms of providing best quality care and services to patients to meet the organization's mission.

4. How did the old governance structure evaluate its effectiveness? How does the new governance structure do the same?

The Board Development Committee was charged with recruiting and retaining, as appropriate, the Community Directors, as well as evaluating the Board's effectiveness and making recommendations for future improvements.

5. What was the direct correlation between the change in governance and improved financial viability? Could the same result have been achieved under the existing governance structure? Why or Why not?

TMC received approximately 8 ½ percent of its operating revenues directly from the City and the County, in terms of the operating subsidies for the care provided, which was a key component, due to the financial strength of the safety net institutions. Truman was one of the first hospitals to go to the non-profit models in the 1960s.

Responding to the question of whether the flexibility and freedom that fostered an entrepreneurial spirit resulted from the governance structure or autonomy in the city and

county governments, Mr. Grimaldi stated it was a combination of several factors, including autonomy, strong leadership, and a strong team.

Pertaining to the kind of labor contracts were in place and whether the government engaged in negotiations, Mr. Grimaldi explained that the contracts were with Truman Medical Centers and were with two separate organizations handled by the management staff. He noted the Board approved what was in those contracts, particularly the financial items. Additionally, he stated the Appropriations Authority of the City and County governments monitored whether TMC stayed true to the mission through annual evaluations.

Regarding whether the financial relationship with the City and County was built into the ordinance that permitted TMC to become a nonprofit corporation, Mr. Grimaldi noted a contract with the City ensured the funds were provided for indigent care and the original covenant or operating agreement with the County bound TMC to operate what use to be Jackson County Public Hospital.

Mr. Grimaldi stated there was a clear distinction between the functions management was empowered to do without Board approval and those functions that required the Board's approval.

Regarding what the amount of funding from the City and County was prior to becoming a 501(C)3 corporation, Mr. Grimaldi stated it was funding through a separate levy for health related purposes adopted by the City and County respectively. He added, at that time, there were not as robust Medicaid or Medicare programs as today; and half of the volume and revenue was generated from the outpatient versus inpatient services.

Regarding the new governance structure at TMC, Mr. Grimaldi stated the size of the Board was reduced from 50 to 33 members and added more accountable governance structure through committees. He agreed to research whether reports describing the governance changes existed, and if so, would submit copies to the HGT.

V. OVERVIEW

A. Comparison of Federal, State, and Local Hospital Funding Sources

Ms. Linda Quick provided a description of the figures reflected in the spreadsheet entitled "South Florida Acute Care Hospital Medicaid-related Financial Data" included in today's agenda package.

Chairperson Zapata noted the HGT should focus on determining what type of structure would work best for the PHT: modify the current structure, change to nonprofit corporation, or change to a special taxing district. He encouraged members to present their recommendations.

Discussion ensued among members regarding what type of governance structure would best serve all aspects of the Jackson Health System.

Mr. Cancela explained his reason for requesting Mr. Rogers' resignation letter be placed on last week's agenda was to recommend that this Task Force develop a two-step recommendation process. These two steps include: 1) a short-term recommendation to amend 25A to create a buffer for the PHT as it currently stands; and 2) a long-term governance structure change that would take up to two years to enact.

VI. WORKING ITEM

A. Discuss/Draft Preliminary Recommendations

Discussion ensued regarding the composition of the proposed new board, the need to ensure members were qualified to serve, and what the level of County Commission control over the hospital board should be. A consensus was reached that short-term recommendation ideas should be dealt with next week and that a copy of the Charter should be available during discussion of possible changes. HGT members also contemplated what number of members would be right for the new board and whether the first step in formatting the recommendations would be amend 25A to reflect the change in membership. HGT members agreed to revisit the referendum language pertaining to the half-penny sales tax and address the conflict of interest aspect of board members.

VII. ADJOURNMENT

The next meeting was scheduled for April 28, 2011, at the State Attorney's Office, 1350 N.W. 12th Avenue, Miami, Florida, at 3:00 p.m.

There being no further business to come before the Hospital Governance Task Force, the meeting adjourned at 6:09 p.m.

Juan C. Zapata, Chairperson
Miami-Dade Hospital Governance Task Force

FINAL OFFICIAL MEETING MINUTES
Miami-Dade County Hospital Governance Taskforce (HGT)

State Attorney's Office
1350 N.W. 12th Avenue,
4th Floor Conference Room
Miami, Florida

April 28, 2011
As Advertised

Harvey Ruvin, Clerk
Board of County Commissioners

Diane Collins, Division Chief
Clerk of the Board Division

Mary Smith-York, Commission Reporter
(305) 375-1598

CLERK'S FINAL OFFICIAL MEETING MINUTES
MIAMI-DADE COUNTY HOSPITAL GOVERNANCE TASKFORCE
APRIL 28, 2011

The Miami-Dade County Hospital Governance Taskforce (HGT) convened a meeting at the State Attorney's Office, 1350 N.W. 12th Avenue, 4th Floor Conference Room, Miami, Florida, on Thursday, April 28, 2011, at 3:00 p.m., there being present Chairperson Juan Carlos Zapata, Vice Chairperson Susan Dechovitz, and Members: Martha Baker, Michael Barron, Jose Cancela, Lee Chaykin, Ed Feller, Robert Johnson, M. Narendra Kini, Marisel Losa, Linda Quick, Sharon Pontious, Lillian Rivera, Donna Shalala, Steven Sonenreich, and Alternate members George Foyo representing Brian Keeley, Janisse Schoepp representing Steven Marcus, and Amy Perry representing Steven Sonenreich; (Members Manuel P. Anton III, Brian Keeley, Steven Marcus, Ana Mederos, Steven Pinkert and Steven Sonenreich were absent).

I. ROLL CALL:
The following staff members were present: Assistant County Attorneys Karon Coleman and Valda Clarke Christian; Gary Collins, S. Donna Palmer, and Angie Martinez, Office of Commission Auditor; and Deputy Clerk Mary Smith-York.

Chairman Juan Zapata called the meeting to order at 3:13 p.m.

II. OPENING REMARKS:
Chairperson Juan C. Zapata advised that he would recognize members Lillian Rivera and Robert Johnson at the start of the Working Item discussion, to address the recommendations, thoughts, and observations they submitted. Additionally, he stated that following Mr. Migoya's presentation, there would be discussion regarding Mr. Jose Cancela's issues regarding the recommendations to the County Commission. Mr. Zapata commented on an article in the "Miami Today" newspaper that misquoted him and cautioned members to avoid speaking with reporters.

III. APPROVAL OF MUNITES (April 14, 2011)

The following corrections to the April 14, 2011, minutes were requested:

- page 2, IV, A, 3 – to include additional points highlighted by Dr. Combes during his presentation.

It was moved by Mr. Cancela, that the April 14, 2011, meeting minutes be approved as amended with the foregoing requested change. This motion was seconded by Dr. Pontious, and upon being put to a vote, passed by a unanimous vote of those members present.

IV. TELECONFERENCE PRESENTATION

Dr. John R. Combes, President/Chief Operations Officer, Center for Healthcare Governance, Chicago, IL, via teleconference, provided a brief overview of the steps

necessary for effective governance. A slideshow of his speaking points was provided for HGT members' reference during the presentation entitled "Practicing Effective Governance." Dr. Combes noted his presentation would focus on how boards were structured and organized, and what core competencies board members needed to function effectively. Speaking points included the following:

- Board Culture
- Key Practices
- Core Competencies
- Using Competencies to Create Effective Governance

Following his presentation, Dr. Combes provided the following responses to questions from HGT members:

Between nine (9) and seventeen (17) members is the recommended number to have an effective board. Having less than nine makes it difficult to create diversity and more than 17 makes it hard to manage.

Generally, the board's membership consists of approximately 25% physicians. Other members of the medical industry should also be included in the board's membership as well, because they bring a certain knowledge that's needed.

Conflicts of interest policies that board members should adhere to included prohibiting members from having any level of material business with the organization or having any business with the organization. Procedures to manage conflicts of interest events, when they occur, must be in place.

Due to current issues regarding finance, more in-boardroom educational programs are recommended.

With regards to reference material on best practices for boards' by-laws, "A Guide to Good Governance" provides sample by-laws, along with rules and procedures. Best practices also include the creation of committees within the board.

Board members need financial literacy because finance is involved in everything the board oversees. Creating an appropriate financial dashboard is a key to having an effective board; however, no template exists for training.

The board should dedicate resources to governance and ensure educational opportunities are available. The board should also have a good relationship with the Chief Executive Officer (CEO).

Self perpetuating board that take the appointment process of nominees serious and spend time working on that process, is the best model of an active governance nominating committee. In a public model, people would present to the County Commission a slate of nominees to be considered.

Representatives from the teaching institution affiliated with the hospital are stakeholders and should have a voice on their perspectives. CEOs and union representatives are representing people's perspectives during the discussion and it is not important that they are unable to vote at the end.

It is important to have open meetings and the best model has a pubic session and follows later with an executive session.

Board committees should consist of board members and non-board members who were not staff members to allow the opportunity for outside expertise.

V. INTRODUCTION AND DISCUSSIONS

Mr. Carlos Migoya, President Elect, Jackson Memorial Hospital, appeared before the HG Task Force and expressed appreciation for the invitation to speak. He stated his primary focus, since being elected as CEO, was internal operations. Mr. Migoya advised that he had no comments pertaining to governance and noted he would not become involved in the process at this point. He addressed the temporary Finance Recovery Board (FRB) proposed by the County Commission that would provide a pathway for the integration of the HGT's work into the system. Mr. Migoya advised that no new resources were being dedicated to fund this board. He noted JMH currently needed approximately $300 million in capital and to build an infrastructure around paying patients and future capital resources. Mr. Migoya advised that an effective, working board operates better with smaller numbers; has representation of stakeholders; and communicates the strategic direction to the Commission. He expressed concern that the Sunshine Law has a negative impact on the board.

In conclusion, Mr. Migoya stated nimbleness was achieved by tax money following the patient; however, JHS needed the time and ability to build its financial situation to the level of its quality of healthcare.

VI. WORKING ITEM

Chairperson Zapata recognized Mr. Cancela to introduce ideas and suggestions that the HGT could recommend to the County Commission.

Mr. Cancela described the proposed 7-member FRB and expressed concern with the lack of language requiring any kind of healthcare expertise as a qualification. He pointed out that the HGT members should take this opportunity to weigh in on the discussion regarding the FRB membership. Mr. Cancela asked members to reconsider its position on proposing language to the Board of County Commissioner (BCC) for consideration on the makeup of the FRB.

Discussion ensued among HGT members concerning the criteria for FRB members and how appointments to fill the seven slots would be made. Issues addressed by members included concerns with language in the resolution establishing the FRB providing that BCC Chairman Joe Martinez would make the Mayoral appointments and HGT's consensus on the 2/3's vote requirement to veto the FRB's actions and to direct any

resolution directing the FRB to act. Members also discussed whether it was in the HGT's scope to make recommendations on the makeup of the FRB, an operational board.

Assistant County Attorney Valda Clarke Christian advised members that the Financial Recovery Board was filed as an assistance measure in response to the Public Health Trust's request for a cash advance for operations funding. She noted the HGT's commentary would not be directed at the FRB; rather would be guidance on how this enterprise should be governed.

Chairperson Zapata suggested the HGT start focusing some of its recommendations on the short-term, and some preliminary recommendations to the County Commission to communicate what direction the HGT was taking.

Ms. Clark Christian advised that the seven FRB appointments would consist of: four (4) by the County Commission, one (1) by the Mayor, one (1) by the AFL-CIO President, and one (1) by the Dade Delegation, and read into the record the qualification criteria for those appointments.

Mr. Cancela recommended a motion and vote be conducted on the 2/3's vote requirement to veto the FRB's actions and the direction to the FRB to act.

Further discussion resulted in consensus among HGT members to focus their recommendations on the 2/3's vote requirement, emphasizing conflict of interest, and diversity. Members agreed to not submit any recommendations regarding qualifications of board members and to specify that the conflict of interest language would apply to stakeholders, as well as board members.

It was moved by Mr. Cancela that the HGT's short-term recommendation to the Chairman and members of the County Commission include the following three (3) points:
1) requirement for 2/3's vote to override the board's action or to override any resolution providing direction to the board;
2) language providing that conflicts of interest and ethics policies also applied to stakeholders; and
3) diversity in board makeup.
This motion was seconded by Mr. Johnson, and upon being put to a vote, passed by a vote of 14-0 (Members Manuel P. Anton III, Brian Keeley, Steven Marcus, Ana Mederos, Steven Pinkert and Steven Sonenreich were absent).

Extensive discussion ensued among members in the development of long-term recommendations.

Following discussion, Chairperson Zapata requested members to review the information provided by Dr. Rivera, Mr. Johnson, and County staff, and submit feedback for compilation and discussion at the next meeting.

Members agreed to conduct the next meeting (May 5th) at the Miami-Dade County Health Department's office in Doral and to each contribute towards providing dinner so the meeting could be extended to complete the list of recommendations.

VII. ADJOURNMENT

There being no further business to come before the HGT Task Force, the meeting adjourned at 6:05 p.m.

Juan C. Zapata, Chairperson
Miami-Dade Hospital Governance Task Force

FINAL OFFICIAL MEETING MINUTES
Miami-Dade County Hospital Governance Taskforce (HGT)

Miami-Dade County Health Department
Center of Excellence
8600 N.W. 17th Street
Miami, Florida 33126

May 5, 2011
As Advertised

Harvey Ruvin, Clerk
Board of County Commissioners

Christopher Agrippa, Division Chief
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Mary Smith-York, Commission Reporter
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CLERK'S FINAL OFFICIAL MEETING MINUTES
MIAMI-DADE COUNTY HOSPITAL GOVERNANCE TASKFORCE
MAY 5, 2011

The Miami-Dade County Hospital Governance Taskforce (HGT) convened a meeting at the Miami-Dade County Health Department facility, 8600 NW 17th Street, Miami, Florida, on Thursday, May 5, 2011, at 3:00 p.m., there being present Chairperson Juan Carlos Zapata, Vice Chairperson Susan Dechovitz, and Members: Martha Baker, Michael Barron, Jose Cancela, Ed Feller, Robert Johnson, Brian Keeley, Marisel Losa, Steven Marcus, Ana Mederos, Linda Quick, Steven Pinkert, Sharon Pontious, Lillian Rivera, Donna Shalala and Alternate member Nancy Humbert representing M. Narendra Kini; (Members Manuel P. Anton III, Lee Chaykin, M. Narendra Kini, and Steven Sonenreich were absent).

I. ROLL CALL:
The following staff members were present: Assistant County Attorneys Karon Coleman, Valda Clarke Christian, and Laura Llorente; Gary Collins, S. Donna Palmer, and Angie Martinez, Office of Commission Auditor; and Deputy Clerk Mary Smith-York.

Assistant State Attorney Paul Silverman, State Attorney's Office, was also present at today's meeting.

Chairman Juan Zapata called the meeting to order at 3:05 p.m.

II. OPENING REMARKS:
Chairperson Juan C. Zapata recognized Mr. Roly Marante, Commissioner Sosa's Chief of Staff (District 6), who would make a brief presentation.

Chief of Staff Roly Marante, County Commission District 6, on behalf of Honorable Commissioner Rebeca Sosa, appeared before the HGT and expressed appreciation to the Task Force for their efforts to make Miami-Dade County a better place to live, work, and play. He spoke about the great need for a change in the Jackson Health System healthcare delivery landscape, which the work being done by this task force would accomplish. Mr. Marante presented a challenge to HGT members to be bold in their recommendations to the County Commission and advised that Commissioner Sosa would be the Prime Sponsor of all recommendations. He informed members that Commissioner Sosa introduced an amendment at Tuesday's (5/3) BCC meeting, providing that all Hospital Governance Task Force recommendations be included in the proposed Financial Recovery Board (FRB); which the Board adopted. Mr. Marante pointed out that the Commissioner Sosa and he purposefully stayed away from the HGT to eliminate the potential for political influence or prejudice. He expressed hopes that the HGT's recommendations were practical, proven and fiscally responsible. In conclusion, Mr. Marante, on behalf of Commissioner Sosa, thanked the members of the HGT for stepping up at a time when the community needed it the most, and looked forward to receiving of the final report. Mr. Marante advised HGT members that earlier tonight Mr. Angel Medina resigned from the Public Health Trust, and quoted the following statement from

Mr. Medina's resignation letter: "...While there are many examples of progress made and renewed accountability, it is evident that a change in governance is necessary and must come rapidly..." Mr. Marante noted that was the reason this task force was created, after which he bid members farewell and exited the meeting.

Chairperson Zapata asked Mr. Marante to convey the HGT's gratitude to Commissioner Sosa for her efforts and inform her that this task force is outstanding and rather than shy away from, it embraced the aggressive timeline placed before it.

Chairperson Zapata provided a brief overview of the items contained in tonight's agenda package and outlined the process for compilation of recommendation into the final format.

III. APPROVAL OF MINUTES (April 21, 2011)

The following corrections to the April 21, 2011, minutes were requested:

- page 2, II., paragraph 3 - to correct the first sentence to correctly read: "...Chairperson Zapata advised that he met with Dr. Eneida Roldan, Chief Executive Officer, JMH, and spoke with BCC Chairman Joe Martinez regarding the HGT's working draft document..."

It was moved by Mr. Johnson, that the April 21, 2011, meeting minutes be approved as amended with the foregoing requested change. This motion was seconded by Mr. Cancela, and upon being put to a vote, passed by a unanimous vote of those members present.

IV. WORKING ITEM

Chairperson Zapata directed members' attention to the emailed document entitled "Hospital Governance Task Force Recommendations" and noted it would be discussed later in tonight's meeting. He advised that Commission Auditor's Office staff member Gary Collins had compiled all HGT members' recommendations into a skeleton document (yellow pages), and would later include additional backup information, the minutes, agendas, and other related documents. Mr. Zapata listed the proposed titles of sections as part of the final report, including the proposed roadmap that was for short-term to have an idea of the County Commission's direction.

A brief discussion ensued regarding the method HGT members would use to construct the final recommendations document from the working draft. Following the discussion, staff member Gary Collins projected a copy of the document on the screen so revisions could be made simultaneously when requests were made by HGT members.

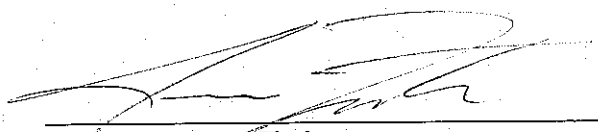
Having concluded development of its final report, the HGT requested Commission Auditor staff to provide a draft to the County Attorney's Office for review and legal sufficiency by Monday, May 9th. Chairperson Zapata asked that, following the County Attorney's review of the draft document, staff member Gary Collins provide HGT

members with a clean draft by Tuesday, May 10th, for review and finalizing at the May 12th meeting.

Members agreed to again hold its next meeting at the Miami-Dade County Health Department facility, 8400 N.W. 17th Street, Miami, and that this would be its final meeting.

V. ADJOURNMENT

There being no further business to come before the HGT, the meeting adjourned at 8:52 p.m.



Juan C. Zapata, Chairperson
Miami-Dade Hospital Governance Task Force

FINAL OFFICIAL MEETING MINUTES
Miami-Dade County Hospital Governance Taskforce (HGT)

Miami-Dade County Health Department
Center of Excellence
8600 N.W. 17th Street
Miami, Florida 33126

May 12, 2011
As Advertised

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Board of County Commissioners

Christopher Agrippa, Division Chief
Clerk of the Board Division

Mary Smith-York, Commission Reporter
(305) 375-1598

CLERK'S FINAL OFFICIAL MEETING MINUTES
MIAMI-DADE COUNTY HOSPITAL GOVERNANCE TASKFORCE
MAY 12, 2011

The Miami-Dade County Hospital Governance Taskforce (HGT) convened a meeting at the Miami-Dade County Health Department facility, 8600 NW 17th Street, Miami, Florida, on Thursday, May 12, 2011, at 3:00 p.m., there being present Chairperson Juan Carlos Zapata, Vice Chairperson Susan Dechovitz, and Members: Manuel P. Anton III, Martha Baker, Michael Barron, Jose Cancela, Ed Feller, Robert Johnson, M. Narendra Kini, Marisel Losa, Steven Marcus, Ana Mederos, Linda Quick, Steven Pinkert, Sharon Pontious, Lillian Rivera, Steven Sonenreich and Alternate members George Foyo representing Brian Keeley and William Donelan representing Donna Shalala; (Members Lee Chaykin, Brian Keeley, and Donna Shalala were absent).

I. ROLL CALL:

The following staff members were present: Assistant County Attorneys Karon Coleman, Valda Clarke Christian, and Laura Llorente; Gary Collins, S. Donna Palmer, and Angie Martinez, Office of Commission Auditor; and Deputy Clerk Mary Smith-York.

Assistant State Attorney Paul Silverman, State Attorney's Office, was also present at today's meeting.

II. OPENING REMARKS:

Chairman Juan Zapata called the meeting to order at 3:02 p.m. and indicated that tonight could be the last time this Hospital Governance Task Force would need to meet. On behalf of the HGT, he expressed appreciation to the County staff from the County Attorney's Office, Commission Auditor's Office, and the Clerk of the Board's Office, for their hard work. Mr. Zapata also thanked each Task Force members for their time and dedication to this critical project.

III. APPROVAL OF MINUTES (April 28, 2011)

It was moved by Dr. Pontious that the April 28, 2011, meeting minutes be approved as presented. This motion was seconded by Mr. Johnson, and upon being put to a vote, passed by a unanimous vote of those members present.

IV. WORKING ITEM

Chairperson Zapata asked members to review the compilation of comments made by each member and advised that Commission Auditor staff member, Gary Collins, would project the working document on the screen and apply revisions as they were made by HGT members.

HGT members Ms. Quick and Dr. Kini commended Gary Collins and Donna Palmer on a great job in producing a well-written document, and the County Attorney's staff for their excellent editing comments.

Discussion ensued among members in response to Dr. Rivera's concern that this final report needed to convey a sense of urgency, with regard to the implementation of the HGT's recommendations. Following discussion, a straw vote determined there was a consensus among members that they would push for urgency in this report.

Ms. Baker noted she was impressed with the new Financial Recovery Board's members' qualifications; however, she expressed opposition with making too many changes too fast. She recommended the new management team and the FRB be allowed to do their work and perform the diligence necessary to make a governance change.

HGT members initiated discussion regarding revising the content of the final recommendation, beginning with clarification of the governance board's purpose and formulation of a title to convey that purpose.

Members Sonenreich and Mederos, and alternate Donelan agreed that the HGT should limit its role to developing recommendations for a governance model and should avoid becoming involved with the FRB.

In response to a poll by Chairperson Zapata to determine if there was consensus on the recommended governance structure as a not-for-profit corporation of not more than nine (9) members (five (5) appointed by the Mayor; four (4) by the County Commission), one member, Ms. Baker, expressed opposition.

Members proceeded to review the working document containing the recommendations submitted, beginning with the Executive Summary and continuing to each category, making revisions throughout the process.

In response to concern that the name for the proposed oversight body should clearly denote that it had no control over the governing board and existed solely to ensure the healthcare system of the County and to ensure the governance body remained true to the healthcare mission. Chairperson Zapata polled members on whether they were in support or opposition to creating an oversight board, which resulted in the following responses:

Members Sonenreich, Cancela, Pinkert, Barron, and Baker expressed opposition to an advisory board; however, he stated if it were to be formed, quarterly reports

Vice Chairperson Dechovitz and Members Pontious, Rivera, Marcus, Kini, Feller, Ms. Quick, Ms. Losa, and Mr. Johnson expressed support for the creation of an advisory board.

Ms. Mederos expressed opposition to a new body being created and noted she would abstain from voting, with regard to this issue.

Dr. Anton stated that, whereas, in order to monitor the unique use of any public funds (half-penny surtax and ad valorem revenue) and in order to create a sense public

accountability to the public body and to the body politic, and in order to facilitate the palatability of the larger recommendations encompassed in this report, he would move that the HGT retain the recommendation for an entity that would be denoted as a public advisory committee, with circumscribed responsibilities to review the use of the unique public funds, and the Safety Net Mission of the Public Health Trust and advise accordingly.

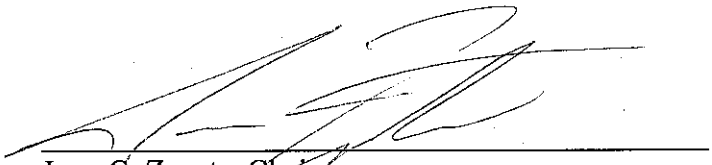
Following a brief discussion, it was the general consensus of the HGT that the name of the oversight board would be "Public Health Advisory Committee" in the final recommendations.

At the completion of the review and revision of draft recommendations, it was moved by Ms. Quick that the recommendations document be submitted as the Final Report as amended with the changes proposed in today's (5/12) meeting. This motion was seconded by Dr. Marcus, and upon being put to a vote, passed by a majority vote of those members present.

Discussion ensued among member regarding the insertion of Ms. Baker's "Minority Report" into the final report. It was suggested that the report be included as an appendix and would not be titled "Minority Report." Following extensive discussion regarding the proper title for this report, it was determined that it would be called "Dissenting View."

Upon acceptance of the final changes to the amended version of the Final Report, Chairperson Zapata requested staff to expedite preparation of a revised document for members' review and approval. He advised that there would be no further meetings and the final version of the document would be distributed by the Office of Commission Auditor's staff. Chairperson Zapata authorized staff to make necessary editorial changes to the extent the content, as approved, was not altered. He requested staff to attempt to obtain the signatures of those members, who did not sign off on the document today, before submittal to the Board of County Commissioners.

There being no further business to come before the HGT, the meeting adjourned at 8:42 p.m.



Juan C. Zapata, Chairperson
Miami-Dade Hospital Governance Task Force

LIST OF TRUST DECISIONS SUBJECT TO THE COMMISSION'S APPROVAL (PRIOR OR SUBSEQUENT) OR THE COMMISSION'S OVERRIDE

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1. **BYLAWS**--The Board of Trustees is empowered to make, adopt and amend the Bylaws of the Trust, but the Bylaws and amendments are not effective until approved by the Commission. Sec. 25A-3(f).

2. **COUNTY ORDINANCES**—Broadly speaking, the Trust cannot take any action that is inconsistent with Ordinances of the County. Sec. 25A-3(f).

3. **CONTRACTS GENERALLY**—The Trust cannot enter into or amend a contract that requires the expenditure of funds in excess of amounts appropriated in the contractual services category of the County budget, without the prior approval of the Commission. Sec. 25A-4(c)(1).

4. **UNIVERSITY OF MIAMI BASIC AFFILIATION AGREEMENT**--The Trust cannot change the contractual relationship with the U.M., without the prior approval of the Commission. Sec. 25A-4(c)(2).

5. **HEALTHCARE DELIVERY POLICIES**--The Trust cannot substantially change the healthcare delivery policies set by the Commission. Sec. 25A-4(c)(3).

6. **COLLECTIVE BARGAINING AGREEMENTS**—The Trust negotiates the Collective Bargaining Agreements with Unions, but the agreements cannot take effect until approved by Commission. Sec. 25A-4(c)(4).

7. **REAL ESTATE**—The Trust cannot acquire real property, without the prior approval of the Commission and the title to such real property must be taken in the name of the County. In addition, the Commission can declassify real property that had been made designated facilities of the Trust and, subject to the prior approval of the Commission, the Trust can accept gifts of real estate. Secs. 25A-4(d), 25A-2, and 25A-4(h).

8. **REAL ESTATE**--Trust cannot sell, convey, mortgage, or encumber title to real estate. Sec. 25A-4(d).

9. **DEMOLITION OF FACILITIES**—The Trust cannot destroy, replace or abandon real estate, without the prior approval of the Commission. Sec. 25A-4(d).

10. **NAMING COUNTY BUILDINGS**—The Trust cannot name buildings without Commission approval. BCC Rule 9.02.

11. **PERSONNEL POLICIES**--The Trust personnel policies are effective, unless overridden by the Commission. Sec. 25A-4(e).

12. **DIRECTIVES**--The Commission can require the Trust by resolution to take or not take certain action. Sec. 25A-4(j).

13. **BUDGET, BORROWING AND BONDS**—The Commission must approve the Trust's budget prior to implementation and the Trust's borrowing of money. Also, the Trust cannot issue bonds but can request the Commission to do so. Sec. 25A-5.

14. **ENABLING STATUTE**—The Commission has the power under Chapter 154, Part II, to amend Chapter 25A to limit the enumerated powers or to totally revoke the statutory trust enabled by Chapter 154, Part II. Sec. 154.11, Fla. Stat.

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Memorandum

MIAMI-DADE COUNTY

Date: February 25, 2010

To: Honorable Commissioner Rebeca Sosa
District 6

From: R. A. Cuevas, Jr.
County Attorney

Subject: Legal issues attendant to current financial exigencies at PHT

You have inquired about the legal responsibilities of the County to the Public Health Trust ("PHT") and Jackson Health System.

LEGAL RELATIONSHIP OF THE PHT TO THE COUNTY:

The County owns Jackson Memorial Hospital ("JMH") and related facilities in the Jackson Health System. It has transferred possession and operating control of these facilities in trust to the "PHT". The beneficiaries of the trust are "the people of Miami-Dade County who, with regard to the Trust, shall be represented only by the Board of County Commissioners." Sec. 25A-7 of the Code of Miami-Dade County. The PHT is an agency and instrumentality of the County.

The PHT has the power to enter into contracts, which as a general matter are not binding on the County. Sec. 25A-4(c) of the Code.[1] The PHT cannot, without prior approval of the County Commission: change the contractual relationship with the University of Miami; enter into any contract the effect of which is to change substantially the health care delivery policies established by the County; or, enter into a contract with any labor union. Id. Because the PHT does not have the independent authority to enter into a labor contract, the County, as a matter of state labor law, is a party to and is bound by the contracts with the PHT's labor unions.

The County is obligated to make certain payments related to the operation or capital needs of the designated facilities operated by the PHT. The County has levied a half cent county public hospital sales surtax the proceeds of which must be utilized for the operation, maintenance and administration of JMH. As a condition of levying the surtax, the County is required to contribute each year a sum of money (maintenance of effort) that is no less than 80 percent of the general fund support provided for the operation of JMH at the time the surtax was levied.

The County has issued revenue bonds for the benefit of the PHT which are secured by certain PHT revenues and by a pledge from the County to replenish certain shortfalls through annual appropriation from legally available, non-*ad valorem* revenues.

[1] There may be instances where, because of the inconclusive status of the law, arguments could be advanced that the County has liability for a particular PHT obligation.

The County has also entered into various Sunshine State loans for certain improvements and equipment for the designated facilities. These loans are secured by and paid from annual appropriation by the County from legally available, non-*ad valorem* revenues.

ENSURING CONTINUED LOCAL CONTROL OVER THE OPERATION OF JMH AND RELATED JACKSON HEALTH SYSTEM FACILITIES:

The question has arisen whether the current financial exigencies of the PHT could jeopardize local control over the operation of JMH and other Jackson Health System facilities.

Neither the County nor the PHT can be involuntarily subjected to the jurisdiction of the federal bankruptcy court. This means that unpaid creditors cannot initiate proceedings in bankruptcy court for the benefit of such creditors.

Chapter 218, Florida Statutes, does provide a state procedure whereby the Governor can initiate oversight of a local governmental entity experiencing a financial emergency if certain statutory conditions are met. Among the statutory conditions that could trigger such oversight are: the failure to pay uncontested claims from creditors within 90 days after being presented as a result of lack of funds; and, the failure for one pay period to pay wages and salaries owed to employees due to lack of funds.

The local governmental entities subject to state oversight under Chapter 218 are a "county, municipality or special district." While the PHT is an agency and instrumentality of the County, it is not clear whether the Governor would consider the PHT to be a part of the County for purposes of Chapter 218. There are no reported cases or Attorney General Opinions holding that an agency or instrumentality of a county is subject to the state oversight process, nor are there any cases or opinions holding that an agency or instrumentality of a county is not subject to the oversight process. Thus, it is unclear whether the Governor would conclude that the PHT could be subjected to the state oversight process if one of the statutory conditions were claimed to exist, or whether a court reviewing a gubernatorial decision to that effect would concur in that decision.

If the Governor concludes the PHT is subject to state oversight, the Governor could implement "assistive measures," including but not limited to: inspecting the local government entity's assets; requiring approval of the local governmental entity's budget; prohibiting the local governmental entity from issuing additional forms of debt; and/or requiring an operational plan that prohibits a level of operations which can be sustained only with nonrecurring revenues.

Expeditious development of a plan to address the current financial exigencies at the PHT affords the best assurance for continued local control over the operations of JMH and related Jackson Health System facilities.

c: Hon. Chairman Dennis C. Moss
and Members, Board of County Commissioners
Hon. Carlos Alvarez, County Mayor
George M. Burgess, County Manager
Dr. Eneida Roldan, President and CEO, Jackson Health System
John C. Copeland, Chairperson, PHT
Alina T. Hudak, Assistant County Manager

Memorandum

MIAMI-DADE COUNTY

Date: March 9, 2011

To: Hon. Commissioner Sally A. Heyman
District 4

From: R. A. Cuevas, Jr.
County Attorney

Subject: Steward's Proposal for acquisition of Jackson Health System

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Steward Health Care System LLC ("Steward") has submitted an Execution Document for Due Diligence Process (the "Proposal") to the County for the acquisition of Jackson Health System ("JHS"). You have asked several questions about this matter. This memorandum responds to your questions and other issues raised when this matter was before the Commission.

I

Your first question asks whether the half-penny sales surtax can be transferred to the proposed new owner.

The County has levied a half-penny County Public Hospital Sales Surtax. The proceeds of this tax can only be used "for the operation, maintenance, and administration of the county public general hospital" defined as a hospital "owned, operated, maintained or governed" by the County or the Public Health Trust ("PHT"). Section 212.055(5), Fla. Stat. As a condition of levying the surtax, the County is required to contribute annually from general county revenues a statutorily defined percentage of the total county budget for the "operation, administration, and maintenance of the county public general hospital." *Id.* The voters of Miami-Dade County approved the levy by referendum. It is my understanding that the combined total of County surtax and maintenance of effort revenues contributed annually to the PHT is over $360 million.

The continued availability of these revenues depends upon whether the hospital, following the contemplated transaction, is a "county public general hospital" as defined in the statute. The Proposal provides "in order to eliminate the [County's] risks associated with the operations of JHS, Steward will assume all responsibility for operations of JHS by acquiring all of the property, plant, equipment and operations of JHS."[1] The Proposal's reference to a continued "robust role" for the County after acquisition by Steward is limited to "providing oversight and input regarding the prioritization of capital, participation in the development of programs for the community, the monitoring quality and patient safety initiatives and the oversight of funds received from the County, whether through the Half-Penny Tax or other sources, for the support of the uninsured/underinsured." Neither the statute authorizing the tax, nor the ballot question posed to the voters to implement it, envision the County's limited role which would result from the transaction suggested in the Proposal.[2] For these reasons, the Proposal does not appear to provide a sound basis for transfer of these revenues to a private owner/operator as proposed by Steward.

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[1] The Proposal is unclear as to the extent of JHS assets to be acquired: whether it's limited to designated facilities managed by the PHT, or includes other facilities operated under the PHT umbrella such as clinics, HMO's, community practices and rentals.

[2] The ballot question provided that the surtax proceeds would be used "for the operation, maintenance and administration of Jackson Memorial Hospital to improve health care services such as: emergency room treatment/trauma care for life-threatening injuries; critical care for infants and children; obstetric and gynecological services; treating cancer and heart disease; treating severe burns, spinal cord injuries, and Alzheimer's disease."

II

Your second question asks whether any agreement we make with Steward binds "our partners, i.e., UM and FIU?" PHT holds Basic Affiliation Agreements and annual operating agreements with the University of Miami and with Florida International University. These agreements establish the relationships between UM/FIU Physicians and PHT. Both Affiliation Agreements contain succession clauses providing that should governance become the responsibility of the County Commission or other entity designated by the Commission, the County Commission or other entity shall succeed the Trust in its rights and obligations under the Agreements. The Affiliation Agreements have four year termination clauses. The Proposal's effect on these agreements should be explored with UM and FIU.

III

Your third question asks what obligations arise out of the proposed due diligence procedure.

The obligations are that the PHT will, within the time frames envisioned in the Proposal, make its records available to Steward and will direct PHT staff to work with Steward on an analysis, evaluations, tours, meetings and discussions thereon.[3] After completion of the due diligence period, Steward will present a proposal to the County for acquisition of JHS. The County will then be free to "shop" that proposal for 30 days to other parties and have two weeks after the close of the 30 day period to compare all proposals received. Steward would have an opportunity to amend its proposal in light of competing proposals submitted by other interested parties and wants the County to respond within one week. The County would have the option of accepting Steward's amended proposal, rejecting it, or entering into negotiations with any other interested party. Should any other party reach successful negotiations with the County, Steward "would be reimbursed by the acquiring party for the costs applicable to its due diligence."[4]

IV

The property on which Jackson Memorial sits is subject to a reverter that provides that it reverts to the City of Miami "in the event Dade County fails to operate a hospital on said premises or on other premises within Dade County offering comparable hospital facilities." The deed further contains a condition that the County shall provide care for the poor, indigent and needy within Miami-Dade County.

The PHT has contracts with various unions that may be affected by the Proposal. The continued applicability of the labor contracts to the surviving entity is an issue under federal law.

JHS also has a number of partners beyond UM and FIU, for example, community practice relationships, whose contractual relationships with JHS may be impacted by the Proposal. Prior to acquisition, as part of the due diligence period, the parties will need to inventory contracts, certificates of need, reimbursement agreements. Those may contain various commitments, for example to provide indigent care, or methods and limitations for assignment.

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[3] The Proposal does not define the level of commitment of PHT resources to the due diligence effort, and is unclear as to how to accomplish the exclusivity that Steward requires during the due diligence period consistent with the requirements of the Public Records law.

[4] The Proposal is silent as to how the reimbursement costs are calculated, how long that reimbursement commitment will be outstanding, and whether it extends beyond this initial process.

Under the state licenses issued for operation of PHT facilities, a change of ownership for hospital and other health care facilities requires sixty day notice to the state, which performs a discretionary review of the change. This approval may affect the length of the due diligence period. Additional licensure and regulatory approval is needed for change of ownership of the JHS non-facility components, for example, the managed care division.

The County has issued a series of bonds in the approximate amount of $273 million for the PHT with an annual debt service of approximately $24.9 million. The bonds pledge all revenues from the operation of the PHT. The legal and financial implications of the Proposal to these bonds must be addressed.

In 2005 and 2006, the County borrowed approximately $87 million under Florida's Sunshine State loan program to benefit the PHT. The legal and financial implication of the Proposal to these loans must be addressed.

As a final matter, the County has the authority to convey JHS pursuant to the usual competitive bid process to the "highest and best bidder" under Florida Statutes section 125.35. It also has the authority to convey a county hospital by means of a negotiated sale under Florida Statutes section 155.40. Embarking on the due diligence procedure contemplated by the Proposal could as a practical and legal matter preclude the ability thereafter to change to a competitive bid process.

The foregoing are the major legal issues presented by the Proposal. We are available to address any of these issues in greater depth at yours or the Commission's convenience.

cc: Hon. Chairman Joe A. Martinez and Members,
Board of County Commissioners
Hon. Carlos Alvarez, Mayor
George M. Burgess, County Manager
Eneida O. Roldan, MD, MPH, MBA,
President and CEO of the PHT
Chair John H. Copeland, III, and Members
of the Public Health Trust

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MEMORANDUM

TO: **Juan Zapata, Chairman;**
Susan Dechovitz, Vice-Chairwoman;
Honorable Members of
The Hospital Governance Taskforce

DATE: **May 6, 2011**

FROM: **Karon M. Coleman**
Assistant County Attorney

SUBJECT: **Sunshine Law,**
Public Records,
Sovereign Immunity &
Public Benefit Corporation

This memorandum is to provide a general framework of the Sunshine Law, the Public Records Act and Sovereign Immunity for the benefit of the Hospital Governance Taskforce as it considers various models of governance for the Public Health Trust and the Jackson Health System. It also explores Public Benefit Corporations.

I. SUNSHINE LAW AND PUBLIC RECORDS ACT[1]

A. **Public Hospitals.** Public Hospitals are subject to the Sunshine Law and the Public Records Act. Section 395.3035, Fla. Stat. However, the following specific activities are exempt from the Sunshine Law and Public Records Act:

1. strategic plans (395.3035, Fla. Stat);
2. contract negotiations with nongovernmental entities (395.3035, Fla. Stat.);
3. managed care contracts (395.3035, Fla. Stat.), trade secrets (395.3035, Fla. Stat);
4. peer review (395.0193, Fla. Stat.);
5. medical review committee/quality evaluations (766.101, Fla. Stat);
6. risk management evaluation of claims and offers of compromise (768.28(16));
7. internal risk management programs (395.0197, Fla. Stat);
8. terrorism, security and emergency management (395.1056, Fla. Stat);
9. security system plans, 286.0113, Fla. Stat.

Several of these exemptions are of limited duration such as strategic planning which requires the transcript of the meeting to be made available to the public upon implementation of the strategic plan or three (3) years whichever is sooner. Others remain exempt without limitation such as peer review and risk management programs.

[1] For purposes of this discussion, reference to the Sunshine Law shall include both Article I, Section 24(b) of the Florida Constitution and Section 286.011 of Florida Statutes and the Public Records Act shall include both Article I, Section 24(a) of the Florida Constitution and Chapter 119 of Florida Statutes.

B. Corporations Created by Government Pursuant to Statute. The Attorney General has opined that entities created pursuant to statute are subject to the Sunshine Law and Public Records Act. See Attorney General Opinions 92-80, 04-44, 98-55, 98-42, 05-27 and 92-53. This would most likely include corporations identified as public benefit corporations. Some of the statutes creating public benefit corporations include provisions specifying that the corporation will be subject to the Sunshine Law and Public Records. See Section 215.56005, Fla Stat. regarding Tobacco Settlement Financing Corporation; See generally Section III for discussion of Public Benefit Corporations.

C. Private Corporations that Lease Public Hospitals. According to Section 395.3036, Fla.Stat.[2], a private corporation that leases a public hospital is exempt from the Public Records Law and the Sunshine Law as long as the public lessor (the government) complies with the public finance accountability provisions of Section 155.40(5),F.S. with respect to the transfer of any public funds to the private corporation[3] and at least three of the following five criteria:

1. the government was not the incorporator of the private corporation;
2. there is no commingling of funds between the government and the private corporation in any account maintained by either entity, except for payment of rent and administrative fees or the transfer of funds pursuant ;
3. the private entity does not participate in the decision-making for the government;
4. the lease agreement does not expressly require the private corporation to comply with the Sunshine Law and Public Records Law;
5. the government is not entitled to receive any revenues from the private entity (except rents or administrative fees) and the government is not responsible for debts or other obligations of the private corporation.

D. Other Models Using Private Corporations. For other models utilizing private corporations, it is necessary to apply the Supreme Court tests for determining if that private corporation is acting on behalf of the government for purposes of the Public Records Act and the Sunshine Law.

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[2] Section 395.3036, Fla. Stat. was found to be a constitutionally permissible limitation on the Sunshine Law and Public Records law, but Section 155.40(6) & (7), Fla. Stat. (2004) -- which declared that the sale or lease of a public hospital was not be considered a transfer of government function and that the lessee was not be acting on behalf of the government – was not constitutional. Baker County Press Inc. vs. Baker County Medical Services, 870 So. 2d 189 (1st DCA 2004), rev. den. 885 So. 2d 386 (Fla. 2004)

[3] Section 154.40(5), Fla. Stat.: "In the event a hospital operated by a for-profit or not-for-profit Florida corporation receives annually more than $100,000 in revenues from the county, district, or municipality that owns the hospital, the Florida corporation must be accountable to the county, district, or municipality with respect to the manner in which the funds are expended by either:

(a) Having the revenues subject to annual appropriations by the county, district, or municipality; or

(b) Where there is a contract to provide revenues to the hospital, the term of which is longer than 12 months, the governing board of the county, district, or municipality must be able to modify the contract upon 12 months notice to the hospital."

1. The Public Records Act. There are two tests that can be applied to determine if the Public Records Act applies to a private entity. The first test is the delegation test: if a public entity delegates a statutorily authorized function to a private entity, any records generated by the private entity's performance of that duty becomes a public record. Memorial Hospital-West Volusia, Inc. v. News-Journal Corp., 729 So. 2d 373, 381 (Fla. 1999); Memorial Hospital-West Volusia Inc. v. News-Journal Corp, 927 So. 2d 961, 966 (5th DCA 2006).

If the delegation of statutory responsibilities is not so obvious, the Supreme Court requires that the matter be analyzed under totality of factors test. News and Sun-Sentinel Co. v. Schwab, Twitty & Hanser Architectural Group, Inc. 596 So. 1029, 1031 (Fla. 1992). In order to determine if a private entity is acting on behalf of government for purposes of the Public Records Act, the following factors are to be considered:

a. the level of public funding;
b. commingling of funds;
c. whether the activity is conducted on publicly owned property;
d. whether services contracted for are an integral part of the public agency's chose decision-making process;
e. whether the private entity is performing a governmental function or a function which the public agency would otherwise perform;
f. the extent of the public agency's involvement with, regulation of, or control over the private entity;
g. whether the private entity was created by the public agency;
h. whether the public agency has a substantial financial interest in the private entity; and
i. for who's benefit is the private entity functioning.

News and Sun-Sentinel Co. v. Schwab, Twitty & Hanser Architectural Group, Inc. 596 So. 2d at 1031. If the combined factual findings regarding the nine (9) factors show that the private entity is acting on behalf of the public entity, then the Public Records Act applies. The Supreme Court has specifically encouraged private entities to review the Schwab factors to determine if they are acting on behalf of the government for purposes of the Public Records Act. Memorial Hospital-West Volusia, Inc. v. News-Journal Corp., 729 So. 2d at 380.

2. Sunshine Law. A private entity is subject to the provisions of the Sunshine Law if a public entity delegates the performance of all or a portion of its public purpose to that private entity. Memorial Hospital-West Volusia, Inc. v. News-Journal Corp., 729 So. 2d at 383; Town of Palm Beach v. Gradison, 296 So. 2d 473 (Fla. 1974). The Fifth District Court of Appeals applied the totality of factors test (used for Public Records Act) to determine whether or not the Sunshine Law applied to a private entity that purchased a public hospital. See Memorial Hospital-West Volusia Inc. v. News-Journal Corp, 927 So. 2d 961, 966 (5th DCA 2006). Also, the Attorney General has opined that receipt of Medicare, Medicaid, government grants or loans by a private hospital does not subject that hospital to the Sunshine Law. AGO 80-45.

E. Public Hospital/Private Corporation Cases. There is an interesting historical interplay between the Florida Legislature and the Florida courts regarding the applicability of the Sunshine Law and Public Records Law to private corporations which lease, operate or purchase public hospitals. The courts were inclined to find that these open government laws applied, while the Legislature kept attempting to exclude these transactions from the Sunshine Law and the Public Records Act. When the Legislature created Section 395.3036, Fla. Stat. (the exemption for private corporations leasing public hospitals), it made the following findings:

> Public entities have chosen to privatize the operations of their public hospitals and public health care facilities in order to alleviate three problems that pose a significant threat to the continued viability of Florida's public hospitals:
>
> (a) A financial drain on the facilities from their forced participation in the Florida Retirement System;
> (b) *The competitive disadvantage placed on these facilities vis a vis their private competitors resulting from their required compliance with the state's public records and public meetings laws*; and
> (c) State constitutional restrictions on public facility participation in partnerships with private corporations as a result of the limitations contained in the State Constitution....

Baker County Press, Inc. v. Baker County Medical Services, Inc. 870 So. 2d 189, 194-95 (1st DCA 2004) quoting Chapter 98-330, Sec. 2 at 2846-47, Laws of Florida (emphasis added).

To learn more about the policy and legal arguments regarding the applicability of the Sunshine Law and the Public Records Act to the sale or lease of public hospitals to private corporations, the following cases are recommended: Sarasota Herald-Tribune Co. v. Community Health Corp., 582 So. 2d 730 (2nd DCA 1991); Memorial Hospital-West Volusia Inc. v. News-Journal Corp., 729 So. 2d 373 (Fla. 1999); Indian River County Hosp. District v. Indian River Memorial Hosp., 766 So. 2d 233 (4th DCA 2000); Baker County Press, Inc. v. Baker County Medical Center, 870 So. 2d 189 (1st DCA 2004); Memorial Hospital-West Volusia Inc. v. News-Journal Corp., 927 So. 2d 961 (5th DCA 2006).

II. SOVEREIGN IMMUNITY

A. In General. Sovereign immunity prohibits/restricts tort suits against the government; government cannot be sued without its consent. According to Article X, Section 13 of the Florida Constitution of Florida Constitution: "Provision may be made by general law for bringing suit against the state as to all liabilities now existing or hereafter originating."

The legislature waived sovereign immunity on a limited basis[4] for state and political subdivisions through enactment of section 768.28 of Florida Statutes. According to 768.28 of Florida Statutes:

> (1) In accordance with s. 13, Art. X of the State Constitution, the state, for itself and for its agencies or subdivisions, hereby waives sovereign immunity for liability for torts, but only to the extent specified in this act. Actions at law against the state or any of its agencies or subdivisions to recover damages in tort for money damages against the state or its agencies or subdivisions for injury or loss of property, personal injury, or death caused by the negligent or wrongful act or omission of any employee of the agency or subdivision while acting within the scope of the employee's office or employment under circumstances in which the state or such agency or subdivision, if a private person, would be liable to the claimant, in accordance with the general laws of this state, may be prosecuted subject to the limitations specified in this act....
>
> * * *
>
> (9)(a) No officer, employee, or agent of the state or of any of its subdivisions shall be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property....

B. State Agencies and Subdivisions. Section 768.28(2) of Florida Statutes defines "state agencies or subdivisions" as "the executive departments, the Legislature, the judicial branch (including public defenders), and the independent establishments of the state, including state university boards of trustees; counties and municipalities; and *corporations primarily acting as instrumentalities or agencies of the state, counties, or municipalities*, including the Florida Space Authority." (emphasis added).

[4] $100,000 for a claim/judgment by one person (increases to $200,000 on October 1, 2011); $200,000 totaling all claims arising from same incident (increases to $200,000 on October 1, 2011). Special Claims Bill must be approved by Legislature for any amount beyond these caps

C. The Public Health Trust. The Third District Court of Appeals found that the Public Health Trust was a state agency pursuant to the definition in Section 768.28 of Florida Statute. Jaar v. University of Miami, 474 So. 2d 239 (3d DCA 1985).

D. Special Taxing District. The Supreme Court concluded that a hospital special taxing district is an independent establishment of the state for purposes of Section 768.28, Fla. Stat. Eldred v. North Broward Hospital District, 498 So. 2d 911, 912 (Fla. 1986).

E. Public Benefit Corporation. There is a strong likelihood that a public benefit corporation would be found to meet the definition of "corporations primarily acting as instrumentalities or agencies of the state, counties or municipalities" in Section 768.28, Fla. Stat.

The case of Prison Rehabilitative Industries and Diversified Enterprises, Inc. v. Betterson, 648 So. 2d 778 (1st DCA 1995) involved a not for profit organization that was mandated by state statute, s. 946.502 Fla. Stat., for the purposes of creating occupational training and other opportunities for inmates. The court held that PRIDE was an agency and instrumentality of the state for purposes of the sovereign immunity statute because the corporation was subject to a number of statutory mandates with regard to its operations –such as who it could contract with and who it could sell its products to – as well as needing approval from the governor regarding its article of incorporation, being subject to state audits, receiving operational funding from the state and being subject to reversion of property to the state if it ceased to exist.

While this state-mandated not for profit corporation is not identified as a public benefit corporation in its enabling statute, it is mostly likely that the analysis for a public benefit corporation would be similar.

F. Corporation Acting as an Instrumentality or Agency.

1. An Issue of Fact. Whether a corporation is acting as an instrumentality or agency of the state, county or municipality is an issue of fact for a judge or jury. Metropolitan Dade County v. Glaser, 1999 WL 89427 (3d DCA 1999).

2. A Matter of Control. Generally, the analysis of whether a corporation is an instrumentality or agency of government centers on the issue of control: the more control that a governmental entity has over the corporation, the more likely the corporation will be found to be an agency and instrumentality of that governmental entity.

a. The control must be more than just control over the outcome, it must be control over the means to achieve that outcome. Dorse v. Armstrong World Industries, Inc., 513 So. 1265, 1268 n.4 (Fla. 1987).

b. Government must be able to control day to day operations. Shands Teaching Hospital and Clinics, Inc. v. Lee, 478 So. 2d 77 (1st DCA 1985).

c. The corporation must be subject to something more than the sort of control that is exercised by the government in its regulatory capacity. U.S. v. Orleans, 425 US 807 (1976).

d. Control that flows from a simple contractual arrangement between a governmental entity and a corporation ordinarily will not be sufficient to establish that the contracting corporation is an instrumentality or agency of the state. Mingo v. ARA Health Services, 638 So. 2d 85 (2nd DCA 1994).

e. Mere fact that corporation is created by the government will not necessarily establish that corporation is a government agency or instrumentality. Doe v. Am. Red Cross, 727 F. Supp 186 (E.D. 1989).

f. An independent contractor is not an agent and therefore "cannot share in the full panorama of the government's immunity." Dorse v. Armstrong World Industries, Inc., 513 So. 1265, 1268 (Fla. 1987).

3. A Few Examples.

a. Pagan v. Sarasota County Public Hosp. Bd., 884 So. 2d 257 (2d DCA 2004) This case provides a good example of a factual finding that a not for profit corporation was an agency and instrumentality of a local government. The Second District Court of Appeals concluded that a not for profit physician's group created by the Sarasota County Public Hospital Board was an agency and instrumentality of the Hospital District Board because the Board had an undeniable right to control the operations of the not for profit physician's group. To wit: the Hospital Board created the not for profit; it had the authority to dissolve it and have its assets revert to the Hospital Board; it elected the not for profit's board members, which included a majority of Hospital Board members; the Hospital District Chief Executive Officer served as the President of the not for profit; and Hospital Board funds were used to create and operate the not for profit.

b. Shands Teaching Hospital and Clinics, Inc. v. Lee, 478 So. 2d 77 (1st DCA 1985). Legislature authorized the lease of Shands Teaching Hospital to a private non-profit corporation organized for the purpose of operating the hospital and other health care facilities. Court concluded that intent of the Legislature was to treat Shands as an autonomous, self-sufficient entity, and not as an instrumentality acting on behalf of state. Additionally, court found that the day to day operations of Shands were not under the direct control of the state and therefore Shands was not an instrumentality of the state for purposes of sovereign immunity.

c. Metropolitan Dade County v. Glaser, 1999 WL 89427 (3d DCA 1999). The County provided operating funds and oversaw expenditures for a public housing tenants'advisory council, but had no control or input into any of the organization's operations or actions, and did not control the outcome of the organizations activities nor the means used to achieve organization's goals; therefore, the County did not have an agency relationship with the organization.

d. Skoblow v. Ameri-Manage, Inc. 483 So. 2d 809 (3d DCA 1986). State entered into a contractual relationship with Ameri-Manage to provide direct management services for South Florida State Hospital, coordinate the development of a long-range plan for the hospital consistent with legislative mandate and assist the state in planning for forensic services. Court concluded that an examination of the relationship was dispositive that Ameri-Manage was operating as an agency of the state.

e. Mingo v. ARA Health Services, Inc. 638 So. 2d 85 (2d DCA 1994). County entered into contract with ARA Health Services to provide medical services to inmates. Based on the plain language of the contract -- which stated that company was providing services as an independent contractor and was not to be considered an agent, employee, partner nor joint venturer of the County – company was not an instrumentality or agent of County for purposes of sovereign immunity.

G. Language of s. 155.40, Fla. Stat. Whereas the language in the sovereign immunity statute indicates that a corporation must be "primarily acting as instrumentalities or agencies of the state, counties, or municipalities," the language in Section 155.40, Fla. Stat. emphasizes that a corporation that leases or purchases a public hospital should not be considered to be "acting on behalf of" a governmental entity. Section 155.40(7), Fla. Stat. states: "The lessee of a hospital, under this section or any special act of the Legislature, operating under a lease shall not be construed to be '*acting on behalf of*' the lessor as that term is used in statute, unless the lease document expressly provides to the contrary." (emphasis added). Also, Section 155.40(8(b) states:

> A complete sale of a hospital as described in this subsection shall not be construed as:
>
> 1. A transfer of a governmental function from the county, district, or municipality to the private corporation or other private entity purchaser;
>
> 2. Constituting a financial interest of the public agency in the private corporation or other private entity purchaser;
>
> 3. *Making the private corporation or other private entity purchaser an "agency" as that term is used in statutes*;
>
> 4. Making the private corporation or other private entity purchaser an integral part of the public agency's decisionmaking process; or
>
> 5. *Indicating that the private corporation or other private entity purchaser is "acting on behalf of a public agency" as that term is used in statute.*

(Emphasis added). And while it appears the Legislature included this language to avoid the application of the Sunshine Law and Public Records Act to corporations that lease or purchase public hospitals, it also has the impact of distancing these corporations from the sovereign immunity statute as well.

The Attorney General has opined twice on whether or not the sovereign immunity statute applies when a public hospital is leased to a private corporation pursuant to Section 155.40, Fla. Stat. In both instances, the Attorney General found that the sovereign immunity statute applied. In the first opinion, the Southeast Volusia Hospital District had formed a not-for profit organization for purposes of operating hospitals and other health care facilities. The District was the sole member of the corporation and the membership of the District Board served as the membership of the Bert Fish Medical Center Inc. Board. Furthermore, the lease agreement indicated that there was intended to be a "transfer of government function" from the District to the corporation, and the corporation was considered to be "acting on behalf of " the district." AGO 05-24.

In the second opinion, the Attorney General also found that Citrus County Hospital Board, a special hospital district, created the Citrus Memorial Health Foundation, Inc, a not for profit corporation, for the purposes of carrying out the responsibilities of the Board. Again, the lease intended to transfer the government function from the Board to the corporation and corporation was to be considered to be acting on behalf of the Board when fulfilling its obligations under the lease. Furthermore, the Board was the sole member of the corporation, the Board appropriated funds to the corporation for the purpose of providing medical care to the residents of the County, in the event of dissolution the assets would revert to the Board and the members of the Board also served as members of the board for the corporation. The Attorney General concluded that the Citrus Memorial Health Foundation Inc was acting primarily as an instrumentality of the Board for purposes of the sovereign immunity statute. AGO 06-36.

In both these cases, the facts supported a finding that the governmental entities exercised sufficient control over the not for profit organizations to support a finding that the corporations were primarily acting as an instrumentality or agent; similar to the Pagan v. Sarasota County Public Hospital case.

H. **Shands Sovereign Immunity Bill**. SB 626. This bill amends Section 1004.41 of Florida Statutes, "University of Florida; J. Hillis Miller Health Center" to recognize Shands Teaching Hospital and Clinics, Inc., Shands Jacksonville Medical Center Inc, Shands Jacksonville Health Care Inc. and any not for profit subsidiary of these corporations as instrumentalities of the state for purposes of sovereign immunity (768.28(2), F.S.). Therefore, while interesting, this bill would not apply to Miami-Dade County, the Public Health Trust or any not for profit that leased the Jackson Health System.

III. PUBLIC BENEFIT CORPORATION

There is no particular statute outlining the particulars of a public benefit corporation. However, disbursed throughout the Florida Statutes are several examples of Florida public benefit corporations. Each one appears distinct in terms of its authority, powers, duties, restrictions and limitations, but they all seem to have something to do with financing. Here are some examples:

A. **Florida Water Pollution Control Financing Corporation.** Section 403.1837, Fla. Stat.. "Florida Water Pollution Control Financing Corporation is created as a nonprofit public-benefit corporation for the purpose of financing or refinancing the costs of projects and activities described in [various statutes]. The projects and activities described in those sections constitute a public governmental purpose; are necessary for the health, safety and welfare of all residents; and include legislatively approved fixed capital outlay projects. Fulfilling the purposes of the corporation promotes the health, safety and welfare of the people of the state and services essential governmental functions and is of paramount public purpose. "

.B. **Inland Protection Financing Corporation**. Section 376.3071, Fla. Stat. "...[I]tis hereby determined to be in the best interest of, and necessary for the protection of the public health, safety and general welfare of the residents of this state, and therefore of paramount public purpose, to provide for the creation of a nonprofit public benefit corporation as an instrumentality of the state to assist in financing the functions provided in [various statutes] and to authorize the department to enter into one or more service contracts with such corporation for the provision of financing services related to such function and to make payments thereunder form the amount on deposit in the Inland Protection Trust Fund, subject to annual appropriations by the Legislature."

C. **Tobacco Settlement Financing Corporation.** Section 215.56005, Fla. Stat. "The Tobacco Settlement Financing Corporation is hereby created as a special purpose, not-for-profit, public benefits corporation, for the purpose of purchasing any or all of the state's right, title, and interest in and to the tobacco settlement agreement and issuing bonds to pay the purchase price therefor which shall be used to provide funding for the Lawton Chiles Endowment Fund. The corporation is authorized to purchase any or all of the state's right, title, and interest in and to the tobacco settlement agreement and to issue bonds to pay the purchase price therefor. The proceeds derived by the state from the sale of any or all of the state's right, title, and interest in and to the tobacco settlement agreement shall be used to fund the Lawton Chiles Endowment Fund. The fulfillment of the purposes of the corporation promotes the health, safety, and general welfare of the people of this state and serves essential governmental functions and a paramount public purpose." Statute specifically makes the corporation subject to Sunshine Law and Public Records Act.

D. **Florida Hurricane Catastrophe Fund Finance Corporation**. Section 215.555(6)(d), Fla. Stat. "In addition to the findings and declarations in subsection (1), the Legislature also finds and declares that: a. The public benefits corporation created under this paragraph will provide a mechanism necessary for the cost-effective and efficient issuance of bonds. This mechanism will eliminate unnecessary costs in the bond issuance process, thereby increasing the amounts available to pay reimbursement for losses to property sustained as a result of hurricane

damage.; b. The purpose of such bonds is to fund reimbursements through the Florida Hurricane Catastrophe Fund to pay for the costs of construction, reconstruction, repair, restoration, and other costs associated with damage to properties of policyholders of covered policies due to the occurrence of a hurricane; c. The efficacy of the financing mechanism will be enhanced by the corporation's ownership of the assessments, by the insulation of the assessments from possible bankruptcy proceedings, and by covenants of the state with the corporation's bondholders. 2.a. There is created a public benefits corporation, which is an instrumentality of the state, to be known as the Florida Hurricane Catastrophe Fund Finance corporation."

E. Other State-Created Corporations. There are other corporations that are created by the state that are not specifically designated public benefit corporations. Again, here are a few examples:

1. Prison Rehabilitative Industries and Diversified Enterprises, Inc. described in Prison Rehabilitative Industries and Diversified Enterprises, Inc. v. Betterson, 648 So. 2d 778 (1st DCA 1995) and created pursuant to Section 946.502 of Florida Statutes (discussed above in II(E)).

2. Work Force Florida Inc.. Created by Section 445.004, Fla. Stat. to be the principal workforce policy organization for the state. Specifically includes a provision to comply with Sunshine Law and Public Records Act.

3. Scripps Florida Funding Corporation. Section 288.955, Fla. Stat. "The corporation shall be organized to receive, hold, invest, administer, and disburse funds appropriated by the Legislature for the establishment and operation of a state-of-the-art biomedical research institution and campus in this state by The Scripps Research Institute. The corporation shall safeguard the state's commitment of financial support by ensuring that, as a condition for the receipt of these funds, the grantee meets its contractual obligations. In this manner, the corporation shall facilitate and oversee the state goal and public purpose of providing financial support for the institution and campus in order to expand the amount and prominence of biomedical research conducted in this state, provide an inducement for high-technology businesses to locate in this state, create educational opportunities through access to and partnerships with the institution, and promote improved health care through the scientific outcomes of the institution" Specifically includes a provision to comply with Sunshine Law and Public Records Act.

F. Expressway Authorities and Transportation Authorities. These entities were considered instrumentalities of the state pursuant to the various statutes in Chapters 343 and 348 of Florida Statutes.

IV. Conclusion

The characteristics that would tend to support the finding that a corporation is acting primarily as an instrumentality or agency of the state, county or municipality – control of the corporation by the governmental entity – for purposes of sovereign immunity tend to also be the same characteristics that would support the conclusion that the corporation is acting on behalf of the state, county or municipality for purposes of the Sunshine Law and the Public Records Act.

Similarly, if a corporation is acting independently enough to be found not to fall within the auspices of the Sunshine Law and the Public Records Act, it is likely to also be found that the corporation is sufficiently separate from government and not to privy to the protections of the sovereign immunity statute.

Also, it seems likely that a public benefit corporation or other statutorily-mandated not for profit corporation would fall within the ambit of the Sunshine Law, Public Records Act and the Sovereign Immunity Statute. However, for other corporations with a contractual relationship with the governmental entity, it would depend on whether or not the corporation was acting on the governmental entity's behalf and the level of control exercised by the governmental entity over the corporation.

Memorandum

MIAMI-DADE COUNTY

Date: May 5, 2011

To: Honorable Chairman Joe A. Martinez
and Members, Board of County Commissioners

From: R. A. Cuevas, Jr.
County Attorney

Subject: Resolution R-392-11 Creating Financial Recovery Board

The Commission this week adopted a resolution establishing a Financial Recovery Board ("FRB") that, under Sec. 25A-9 of the Code, will replace the current Board of Trustees as the governing body of the Public Health Trust ("PHT"). The FRB will have seven (7) members. The Commission will appoint four (4) members and the Mayor, Chairperson of the Miami-Dade Legislative Delegation and the President of the South Florida AFL-CIO will each designate one member, subject to ratification by the Commission.

The resolution incorporates several recommendations from the Hospital Governance Taskforce ("Taskforce"). One of the recommendations significantly expands the scope of what constitutes a conflict of interest beyond the current, applicable requirements contained in the Conflict of Interest and Code of Ethics Ordinance ("Conflict of Interest Code") and limits who may be considered for selection and appointment to the FRB. The Taskforce's recommendation is worded as follows:

> We urge emphasis on ethics and absence of perceptions of conflicts of interest in the governing body. Members should have no conflicts of interest, personally or as stakeholders, in the outcome of their decisions. The governing body's sole interest should be the future of Jackson Healthcare System [sic].

The Taskforce Chair's transmittal letter characterizes this requirement as follows:

> ...the governing body must be able to show that it can nimbly and without perceptions of conflicts of interest make the necessary tough decisions in consultation with stakeholders.

The Commission has asked how this heightened standard regarding conflicts of interest should be applied when considering persons for nomination and appointment (or designation and ratification) to the FRB.

As an initial observation, the Board of Trustees, as the current governing body of the PHT, is subject to the Conflict of Interest Code. Sec. 25A-9 provides that the members of the FRB will be subject to the same standards of conduct, including the Conflict of Interest Code, as the current governing body of the PHT. Under the Conflict of Interest Code, the currently sitting members of the Board of Trustees of the PHT are precluded from participating and voting on particular PHT matters in which they could be uniquely benefitted or financially interested.

They also are generally precluded from transacting business with the PHT, from soliciting or accepting gifts for actions taken in their official capacity, and from exploiting their official position or disclosing confidential information acquired by reason of their official position. Collectively, these proscriptions do not serve to preclude someone from serving on the Board of Trustees who may work for an entity or organization that has a financial interest in certain actions which the PHT may take. The proscriptions may, however, preclude an affected Trustee from participating and voting in a particular matter where that interest is implicated.

The heightened standard regarding conflicts of interest contained in the Taskforce's recommendation goes beyond the Conflict of Interest Code to include "perceived" conflicts of a personal nature and "as stakeholders, in the outcome of .... [FRB] decisions." The meaning of the term "stakeholders" in the commercial context traditionally refers to individuals or organizations that have a financial or strategic business interest in the business of another organization or entity. Although not defined in the Taskforce's recommendation, a "perceived" conflict of interest is one that a third party might reasonably believe could cause the individual's action or advocacy to be affected by conflicting duties or loyalties whether or not an actual conflict exists.

The FRB will have to make decisions or take action concerning Jackson Health System ("Health System") which includes: five (5) hospitals, the Ryder Trauma Center, a health plan, nursing homes, primary care centers, corrections health, community physician practices, and various related programs and lines of business. There are many stakeholders with respect to each of these aspects. In the case of the Health System which the FRB will be charged with governing, stakeholders would include competitors, contract partners, affiliates, or other groups, institutions, entities or individuals having a financial or strategic business interest in the outcomes of the FRB's decisions or proposed actions, and officers and employees thereof.

"Perceived" conflicts and "stakeholder" conflicts as articulated in the heightened conflict of interest standard preclude appointment to the FRB of potential nominees who would otherwise be eligible to serve on the Board of Trustees currently acting as the governing board of the PHT. In particular, nominees who hold a position with any of the following entities or organizations would not be eligible to serve on the FRB so long as they continue to hold such position:

1. Competitors of the PHT (e.g., another health plan or nursing home) or employees, officers, owners, partners or board members of a competitor;

2. Vendors of the PHT or employees, officers, owners, partners or board members of a vendor of the PHT;

3. Affiliates or contract partners of the PHT (e.g., The University of Miami or The Florida International University) or employees, officers, owners, partners or board members of an affiliate or contract partner;

4. Physicians, healthcare professionals or other providers on the medical staff of a hospital or health system or otherwise competing with the Health System; and

5. Officers and members of the various unions who have entered into collective bargaining agreements with the PHT.[1]

The above list is not exhaustive but is intended to provide guidance to the Commission (and the other designating authorities) when selecting members to the FRB. Application of this heightened standard to prospective appointments to the FRB still may require a case-by-case determination by the Commission.

cc: Alina T. Hudak, County Manager
Charles Anderson, Commission Auditor
Robert Meyers, Executive Director,
Commission on Ethics and Public Trust
Hon. Harvey Ruvin, Clerk of the Board
Christopher Agrippa, Transitional Division Chief,
Clerk of the Board Division
Carlos A. Migoya, President and CEO, PHT
Marcos J. Lapciuc, Esq. Chairman,
Board of Trustees of the PHT
Juan C. Zapata, Chairman
Hospital Governance Taskforce

[1] Sec. 25A-9 of the Code provides that the President of the South Florida AFL–CIO may designate a person to serve as a member of the FRB, subject to Commission ratification.

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Background Information
Boston Medical Center (BMC), Boston, MA

Legal Structure, Governance, and Mission

Ownership: Private nonprofit

Governance change:

- In July 1966, two Boston public hospitals (one acute; one long-term care that was closed in 90 days by the agreement) and a private, non- profit hospital (Boston University Medical Center Hospital that was on the campus of but not owned by Boston University) consolidated to form the new, non-profit Boston Medical Center; change required state legislative changes.
- Boston Public Health Commission, a seven-member board, created by the same legislation to provide for public health responsibilities.

Governance: BMC Board of Trustees

Operation: Private nonprofit

Mission:

- Academic medical center and the primary teaching affiliate for Boston University School of Medicine
- Largest safety net hospital in New England and reaches into the community as a founding partner of Boston HealthNet, a network of 15 community health centers through Boston serving more than a quarter million people annually.(In 1997 provided $146 million in free care to vulnerable population)
- Largest 24-hour Level I trauma center in New England
- Boston Medical Center is a recognized leader in groundbreaking medical research. Boston Medical Center
- More than $126 million in sponsored research funding in 2010, and oversees 581 research and service projects separate from research activities at Boston University School of Medicine
- Mission to provide exceptional care, without exception

Beds: 639 (per 2009 Annual Report & BMC website)

Employees: 5,121 (per 2011 AHA Guide)

Clinics: Founding partner of 15 Community Health Centers

Sunshine and Sovereign Immunity

Sunshine: No Sovereign Immunity: No

Hospital or Health System: Hospital

- Founding partner of Boston HealthNet, a network of 15 community health centers through Boston serving more than a quarter million people annually.

Board and Autonomy: 30 Trustees

- 10 appointed by the mayor of Boston
- 10 were appointed by the board of the nonprofit hospital in the merger
- 6 ex officio members
- 4 senior officials or physicians appointed by neighborhood health centers in Boston HealthNet

Financial Relationship with County/City: Limited; debt service on City of Boston owned property

Budget Approval

- Operating: Trustees. Capital: ?

Background Information
Boston Medical Center (BMC), Boston, MA

Assets
- Some BMC/some City of Boston
- Includes physical plant 90 year lease from City of Boston (Boston Public Health Service Commission)

Teaching Hospital: Yes; primary academic teaching hospital for Boston University School of Medicine

Independence: ?

Medical Staff
- Staffing: 1,300 Physicians
- Physicians' compensation for indigent care: ?
- Physicians' compensation for teaching: ?

Unions
- 10 bargaining units, 4 unions
- Labor contracts are not civil service

Unfunded Care
- How funded, percent funded, & limits: ?
- Contract with local government to fund indigent care: ?
- Federal and/or state funding: For indigent care via various mechanisms

Payor Mix
- 50% Low-income – Medicaid/Health Safety Net Pool (compensated uninsured)
- 30% Medicare
- 20% Commercial, self-pay & others

Revenues
BMC fiscal year ending September 30, 2009 (per BMC 2009 Annual Report)
- Medicare ?
- Medicaid ?
- Charity Care ?
- Net Patient Revenue $874 million
- Grants & Contract Revenue $82 million
- Other Revenue $37 million
- Total Operating Revenue $993 million

Expenses
BMC fiscal year ending September 30, 2009 (per BMC 2009 Annual Report)
- Salaries, Wages and Benefits $440 million
- Total Operating Expenses $1,017 million

Loss from Operations (per BMC 2009 Annual Report): $25 million

Background Information
Cook County Health and Hospitals System (CCHHS), Chicago, IL

Legal Structure, Governing, and Mission

Ownership:	Government (Cook County, IL)
Governance:	11-member Cook County Health & Hospitals System (CCHHS) Board of Directors
Governance Change:	?
Operation:	Government (CCHHS Board of Directors)
Mission	Provide a comprehensive program of quality health care with respect and dignity, to the residents of Cook County, regardless of their ability to pay.
Beds:	895
Employees:	6,319 full time employees

Sunshine and Sovereign Immunity

- Sunshine: Yes Sovereign Immunity: No (see note below)

Note: CCHHS is included in Cook County self-insurance program. Individuals/patients could sue the health system for malpractice. However, the County Code requires the County to defend and indemnify patient care personnel, public health practitioners (including physicians), the Nominating Committee and the CCHHS Board of Directors, with specified exceptions.

Hospital or Health System: Health System

- John H. Stroger, Jr. Hospital (Flagship Institution). Includes 464 beds, 400 residents and fellows, 300 attending physicians; anchored by 228 medical/surgical beds, with dedicated units for obstetrics, pediatrics intensive care, neonatal intensive care, and burns; 40% of the hospital's space is used for outpatient care, specialty diagnosis and treatment.
- Provident Hospital
- Oak Forest Hospital
- 16 Ambulatory and Community Health Network Clinics
- Cook County Department of Public Health
- Cermak Health Services (correctional health care)
- Rothstein CORE Center
  Note: Each of the systems is lead by a Chief Operating Officer (COO).

Board and Autonomy

- 11-member CCHHS Board of Directors with appointed Directors limited to no more than two consecutive five-year terms
- Accountable to: Cook County Board of County Commissioners
- Nomination & selection: Cook County Board of Commissioners created a Nominating Committee of distinguished professionals, which selected 20 individuals from which the Chairman of the Board selected 11 for final consideration by the Board of County Commissioners. One of the 11 Directors shall be the Chairperson of the Health and Hospitals Committee of the County Board and shall serve as an ex officio member with voting rights.
- County Commissioners approve annual operating & capital budget, real estate transactions above a certain limit ($100K), and other transactions above $1 million.
- The CCHHS Board of Directors has authority to set salaries and compensation for executives and physicians.

Background Information
Cook County Health and Hospitals System (CCHHS), Chicago, IL

Financial Relationship with County/City
- 2009 CAFR shows CCHHS revenues a proprietary fund of Cook County
- Taxing Authority: No, CCHHS does not have authority to increase taxes, request for tax increases to support the health system are submitted to Cook County Board of Commissioners.
- Percentage of Operating Funds from State/Local Government: ?
- Percentage of Operating Revenue received from City/County (Taxes): 39.6% ($452.9 million)

Budget Approval:
- Operating Budget: Cook County Board of Commissioners
- Capital Budget: Cook County Board of Commissioners

Assets Ownership: Cook County owns the facilities/assets

Teaching Hospital
- John H. Stroger, Jr. Hospital (Flagship Institution): Yes; has an academic affiliation with Rush Medical College for both undergraduate and graduate medical education, RFUMS(Rosalind Franklin University of Medicine and Science) / The Chicago Medical School, and the Chicago College of Osteopathic Medicine for medical rotations.
- Provident Hospital: No
- Oak Forest Hospital: No

Independence
- Labor Contracts (Authority to approve): Board of Commissioners (Cook County)
- Executive Compensation (Authority to approve): Health System Governing Board

Medical Staff/General Staff
- General Staff/Full Time: 6,319 employees
- Part Time: 676 employees

Unions:
- Hospitals and Health Care Employee Union
- SEIU 73
- Doctors Council
- NNOC – (National Nursing Organization Council)

Note: These unions include more than 60% of the health system workers

Unfunded Care:
- How funded, percentage funded, & limits: ?
- Contract with local government to fund indigent care: ?
- Federal and/or state funding: ?
- Value of Uncompensated Care: $321.3 million (FY ended November 30, 2009)
- Subsidies from Cook County: $217 million (based on budget plans for 2011)

Background Information
Cook County Health and Hospitals System (CCHHS), Chicago, IL

Payor Mix (FY 2009)
- Medicare: 9 %
- Medicaid: 32%
- Other: 7%
- Self-Pay: 52%

Revenues
- Medicare: $56.6 million (9%)
- Medicaid: $201.4 million (32%)
- Other: $44 million (7%)
- Self Pay: $327.3 million (52%)

Total Operating Revenues – $629,542,075 ($599.5 million from net patient revenue)

Non Operating Revenues (from tax sources) - $452,968,729
- Sources of Non-Operating Revenue:

Property Taxes	$138,561,251
Sales Taxes	$285,027,113
Cigarette Taxes	$29,380,365

- Percentage of revenues from City/County: 39 %

Note: Sales tax support scheduled to be rolled back to 1.25% on July 1, 2011

Background Information
Los Angeles County (LAC) Department of Health Services (DHS)

Legal Structure, Governance, and Mission

Ownership: Los Angeles County, CA

Governance: Government, Los Angeles County Board of Supervisors

Governance Change: None, but LA County has a conducted or been the subject of a substantial number of studies of health system governance. For example, a 2004-2005 Los Angeles County Civil Grand Jury report provided in-depth analysis on creating a hospital authority to replace DHS.

DHS Executive Team:
- Mitchell H. Katz, M.D., Director
- John F. Schunhoff, Ph.D., Chief Deputy Director
- Vivian C. Branchick, RN, MS, Chief Nursing Officer & Director of Nursing Affairs
- Cheri Todoroff, MPH, Deputy Director, Planning & Program Oversight
- Nina Park, M.D, Interim Chief Medical Officer, Division of Ambulatory/Managed Care
- Kevin Lynch, MS, Chief Information Officer
- Gregory Polk, MPA, Administrative Deputy

Mission:
- Ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners. DHS has an annual budget of $4 billion and about 20,000 employees.
- The Los Angeles County Department of Health Services (DHS) is the second largest public health system in the nation. DHS serves the healthcare needs of nearly 10 million residents. DHS provides acute and rehabilitative patient care, trains physicians and other health care clinicians, and conducts patient care-related research.
- DHS also operates the Los Angeles County's Emergency Medical Services Agency and is responsible for planning, monitoring, and evaluating the local EMS system. L.A. County's EMS agency is the largest multi-jurisdictional EMS system in the country with more than 18,000 certified EMS personnel employed by fire departments, law enforcement, ambulance companies, hospitals, and private organizations to provide lifesaving services 24/7.

Beds: In FY 2010-11, DHS has a total of 1,469 budgeted beds.

Employees: In FY 2010-11, DHS has 20,248 in budgeted positions in areas such as research, clinical care, human resources, information technology, finance, and more. As of February 2011, the number of Full-Time Equivalents (FTEs) in DHS is 17,423.

Sunshine and Sovereign Immunity: ***Dr. Schunhoff to address***

Hospital or Health System: Health System
- Four hospitals: LAC+USC Healthcare Network, Harbor-UCLA Medical Center, VallyCare Olive View-UCLA Medical Center, and Rancho Los Amigos National Rehabilitation Center.
- Two multi-service ambulatory care centers - High Desert Health System and Martin Luther King, Jr.
- Six comprehensive health centers, multiple health centers throughout the Los Angeles County, many in partnership with private, community-based providers, and numerous health clinics.

Background Information
Los Angeles County (LAC) Department of Health Services (DHS)

Board, Selection, and Autonomy: ***Dr. Schunhoff to address***

Financial Relationship with County/City:
- DHS is 100% owned/operated by the County of Los Angeles
- Over $640 million was budgeted as General Fund operating subsidies for the Hospital Enterprise Funds in the adopted FY 2010-11 County budget.

Budget Approval: Los Angeles County Board of Supervisors

Assets: County owns facilities.

Teaching Hospital: Yes.
- University of Southern California School of Medicine
- UCLA School of Medicine
- Charles R. Drew University of Medicine and Science

Independence: ***Dr. Schunhoff to address***
- Labor Contracts and Compensation: ?
- Contracting Authority for Goods and Services: ?

Medical Staff: ***Dr. Schunhoff to address***
- Staffing: ?
- Physicians' compensation for indigent care: ?
- Physicians' compensation for teaching: ?

Unions: ***Dr. Schunhoff to address***

Unfunded Care: DHS serves as the major provider of healthcare for the more than two million county residents without health insurance and provides the majority of all uncompensated medical care in the county.

Federal *	38.9%
State **	22.2%
County ***	38.9%
Total	100.0%

Payor Mix

Patient Mix	Hospitals - Inpatient	Hospitals - Outpatient	Multi-service Ambulatory Care Centers	Comprehensive & Community Health Centers
Medi-Cal	43.1%	23.9%	20.5%	10.9%
Uninsured	41.4%	49.0%	62.6%	73.7%
Medicare	8.2%	8.8%	6.0%	2.9%
Other Third Party	6.3%	10.5%	7.2%	3.9%
Other Payor	1.0%	7.8%	3.7%	8.6%
Total	100.0%	100.0%	100.0%	100.0%

Background Information
Los Angeles County (LAC) Department of Health Services (DHS)

Revenues

FY 2011 Budget:

- The adopted FY 2010-11 budget included $640 million as an "Operating Subsidy – General Fund" for the Hospital Enterprise Funds.
- At the time the Los Angeles County Board of Supervisors adopted the Department of Health Services' (DHS) FY 2010-11 Final Budget on September 28, 2010, the budget included an unsolved deficit of $253.3 million.
- Based on the latest DHS Fiscal Outlook update presented to the Board of Supervisors on March 29, 2011, the current FY 2010-11 estimated shortfall is now $68.8 million.
- The majority of the funding solutions come from various elements of the new Waiver.
- DHS continues to work with the County Chief Executive Office to resolve the remaining deficit for FY 2010-11.

LA County Reports on Health System Governance

- LA County has conducted or been the subject of a substantial number of studies of health system governance. For example, a 2004-2005 Los Angeles County Civil Grand Jury report provided in-depth analysis of creating a hospital authority.
- The below list of reports was extracted from the DHS Office of Planning and Analysis webpage. It is available online by following the "DHS Governance Reports" link on the webpage, http://www.ladhs.org/wps/portal/Planning.

Office of Planning and Analysis - DHS Governance Reports

- Los Angeles County Civil Grand Jury 2004-2005 Final Report: Health Authority Subcommittee findings pp. 43-165
- LAC Chief Administrative Office Health Authority Blue Print: Additional Information -- 6/28/05
- LAC Chief Administrative Office Health Authority Blue Print: Preliminary Report -- 4/18/05
- Hospital Association of Southern California: Health Care Authority Brief -- 6/6/03
- USC: Analysis of Alternate Governance for LAC Department of Health Services -- May 2003
- LAC Ad Hoc Hearing Body on Governance: Final Report -- 2/5/02
- LAC Chief Administrative Office: Action Plan for Conversion to Alternative Governance Models -- 2/1/02
- LAC Chief Administrative Office: Governance of the Department of Health Service -- 8/29/01
- LAC Health Crisis Manager: Governance of the Department of Health Services -- 12/12/95

Other Public Health Governance Reports

- Hennepin County Medical Center Governance Transition Committee Reports
- National Association of Public Hospital Safety Net Hospitals: Governance - Issue Brief -- Sept. 2003
- American College of Healthcare Executives: Governance Change for Public Hospitals--1999

Grady Memorial Health System (GMHS), Atlanta, GA

Legal Structure, Governance, and Mission

Ownership: Fulton-DeKalb Hospital Authority

- The Fulton-DeKalb Hospital Authority (FDHA) was created to oversee the operations of Grady Health System.
- Consists of 10 members. The Fulton County Board of Commissioners appoints seven members and the DeKalb County Board of Commissioners appoints three members.[1]
- Term: Staggered terms of four years

Governance: Private nonprofit corporation (Grady Memorial Hospital Corporation)

Operation: Grady Memorial Hospital Corporation Board of Directors

- In January 2008, a coalition of state and community leaders agreed to create the Grady Memorial Hospital Corporation, a nonprofit corporation charged with administering the hospital; members of a new seventeen-member board were announced in March 2008.
- In response to the board's fund-raising campaign to raise $100 million for the hospital, the Robert W. Woodruff Foundation pledged $200 million over four years, and the medical insurance company Kaiser Permanente pledged $5 million.

Governance change:

- Originally owned by the two Georgia counties: Fulton and DeKalb.
- In January 2008, a coalition of state and community leaders agreed to create the Grady Memorial Hospital Corporation, a nonprofit corporation charged with administering the hospital, and in March members of a new seventeen-member board were announced.
- In response to the board's fund-raising campaign to raise $100 million for the hospital, the Robert W. Woodruff Foundation pledged $200 million over four years, and the medical insurance company Kaiser Permanente pledged $5 million.
- Grady Memorial Hospital Corporation (GMHC) is a nonprofit corporation established to oversee the operations of Grady Health System under a 40 year lease.

Mission:

- Grady improves the health of the community by providing quality, comprehensive healthcare in a compassionate, culturally competent, ethical and fiscally responsible manner.
- Grady maintains its commitment to the underserved of Fulton and DeKalb counties, while also providing care for residents of metro Atlanta and Georgia. Grady leads through its clinical excellence, innovative research and progressive medical education and training.
- Excellence — Grady Health System strives for the highest quality in all that we do. The art and science of health require a commitment to lifelong learning and professionalism.
- Customer Service — Grady Health System is motivated by a sincere concern for the well-being of all people and we will strive to serve everyone with dignity, respect and compassion.
- Ethics — Grady Health System will maintain the highest ethical standards through its actions and decision.
- Teamwork — Grady Health System cultivates an environment of communication, respect, trust and collaboration.
- Commitment — Grady Health System is motivated by pride and dedication, determined to achieve goals of the organization and willing to give our best efforts at all times.

Beds:	953
Employees:	4,850 (excluding Physicians)
Physicians:	1,100 (including residents)
Neighborhood Health Centers:	8

[1] Source: Fulton-Dekalb Hospital Authority website, http://www.gradyhealth.org/fdha.html

Grady Memorial Health System (GMHS), Atlanta, GA

Sunshine and Sovereign Immunity
Sunshine: Yes Sovereign Immunity: No

Hospital or Health System: Healthcare system
- Grady Health System is one of the largest public health systems in the United States. Grady consists of the 953-bed Grady Memorial Hospital, eight neighborhood health centers, Crestview Health & Rehabilitation Center - and Children's Healthcare of Atlanta at Hughes Spalding, which is operated as a Children's affiliate.

Board Selection and Autonomy
- Consists of 17 members.
- Staggered terms of one to three years.
- Selection from a pool of candidates from nomination committee and serving Board Members.

Financial Relationship with County/City
GMHS is on 40-year leasehold interest from Fulton-DeKalb Hospital Authority.
- GMHS is a Private Nonprofit.
- Percentage of operating funds from County:
- FY 2009 FY 2010
- $56.8. Million $52.9 million
-

Budget Approval
- Independent of the County.

Assets:
- Owned by the county. Sales or subleasing requires approval from County.
- GMHS capital assets are on 40-year leasehold from Fulton County

Teaching Hospital: Yes
- Grady is an internationally recognized teaching hospital staffed exclusively by doctors from Emory University and Morehouse schools of medicine.

Independence:
- No labor unions.
- Contracting Authority for Goods and Services: GMHS Board of Directors

Medical Staff
- Physicians are staff of Emory University and Morehouse schools of medicine.
- Nurses are GMHS employees.
- Physicians' compensation for indigent care.(Handled by the Group Billings)
- GMHS has yearly contractual amount it pays to the medical schools that enables the physicians to provides services to GMHS Patients whether insure or not.
- Physicians' compensation for teaching is handled by the medical schools
- GMHS contracts with the medical schools that covers yearly pay(an agreed contractual amount)

Unions: No

Grady Memorial Health System (GMHS), Atlanta, GA

Unfunded Care

- How funded, percent funded, & limits:
- Contract with local government to fund indigent care: The two counties, Fulton and DeKalb, provide some funding; in 2010: Fulton $68 million & DeKalb $18 million.
- Federal- Disproportionate share hospital funds DSH Fund
- State funding: No.

Payor Mix	FY 2009	FY 2010
– Medicare	16.6%	17.2%
– Medicaid	33.0%	32.4%
– Insurance	16.8%	?
– Uninsured	33.6%	34.4%

Revenues	FY 2009	FY 2010
– Net Non Operating revenue	$17.8 million	10.9 million
– Net Patient service Revenue-	$270.2 million	$293.6 million
– Total Operating Revenues -	$387.6 million	$420.5 million
– Indigent Care Trust Fund Rev.	$54.2 million	$60.1 million
– Grant & Other revenue-	$63.2 million	$68.8 million
– County Support	$56.8 million	$52.9 million

Expenses	FY 2009	FY 2010
– Salary and Wages	$297.4 million	?
– Contractual Payments	$3.4 million	$4.1 million
– Total Operating Expenses	$473.8 million	$478.4 million

Loss from Operations	FY 2009
– Loss	$11.5 million

Background Information
Harborview Medical Center (HMC), Seattle, WA

Legal Structure, Governance, and Mission

Ownership: King County, WA
Governance: Harborview Board of Trustees; HMC is a separate legal entity having its own corporate powers[1]
Operation: University of Washington (contracted)
Mission:

- One of two academic medical centers in UW Medicine health-care system
- The only Level I adult and pediatric trauma and burn center serving Washington, Alaska, Montana and Idaho
- Offers highly specialized services, such as trauma and burn care, as well as neurosurgery, eye care, vascular, rehabilitation, sleep medicine and spine care
- Primary mission is to provide and teach exemplary patient care and demonstrate an unwavering commitment to those patients and programs for the priority population groups identified by King County (including: incarcerated persons, mentally ill, STDs, trauma, and others). It also is the Disaster Control Hospital for Seattle and King County.

Beds: 413
Employees: 4,432 (UW employees)
Clinics:

- Center of Neurosciences
- Center of Trauma
- Center of Burn care
- Center of Reconstruction and rehabilitation
- Orthopaedics
- Global health
- Sleep medicine
- Sports and spine care
- Vision and eye care
- Vascular surgery
- Center of Mental health, substance abuse and chronic medical disease
- Center of AIDS/sexually transmitted diseases

Sunshine and Sovereign Immunity

Sunshine: Yes Sovereign Immunity: Not for staff (which are UW)

Hospital or Health System: Hospital

- Part of UW Medicine health-care system, which also includes UW Medical Center, the UW School of Medicine, UW Neighborhood Clinics, Northwest Hospital & Medical Center and Airlift Northwest, an emergency air transport service that serves the region.

Board and Autonomy

- 13 Trustees appointed by elected County Executive and confirmed by Council
- 4-year terms (maximum of 3 terms)
- "Trustees determine major institutional policies and retain control of programs and fiscal matters...accountable to the public and King County for all financial aspects of HMC's operations

[1] Note 1 to King County, Washington, Financial Statements, December 31, 2009

and agree to maintain a fiscal policy that keeps the operating program and expenditures of HMC within the limits of operating income." [1]
- "County cannot impose its will on HMC." [1]

Financial Relationship with County/City
- HMC pays annual rent to King County for facilities
- 2009 CAFR shows HMC revenues to King County of $6.1 million
- Per King County Prosecuting Attorney's Office, HMC does have taxing authority but was not being exercised; King County does not pay for indigent care
- Percentage of operating funds from County: ?

Budget Approval
- Operating: Trustees. Capital: County approval for bonds

Assets: County owns facilities.

Teaching Hospital: Yes; one of two academic medical centers in UW Medicine health-care system. UW manages HMC under contract.

Independence:
- Labor Contracts and Compensation: Staff are UW employees.
- Contracting Authority for Goods and Services: HMC Board of Trustees
- See "Boards and Autonomy" section on previous page.

Medical Staff
- Staff: Are UW employees
- Physicians' compensation for indigent care: ?
- Physicians' compensation for teaching: ?

Unions
- Hospitals and Health Care Employee Union
- SEIU 1199 Northwest

Unfunded Care
- How funded, percent funded, & limits:
- Contract with local government to fund indigent care:
- Federal and/or state funding:

Payor Mix ($ in millions)

Categories	Amounts	Percentage
Inpatient Revenue	$1,015	70.8%
Outpatient Revenue	$418	29.2%
Medicare	$236	16.5%
Medicaid	$209	14.6%
Charity Care	$155	10.8%
Other	$203	14.2%

Total Patient Services Revenue	$1,433	100%

Revenues

HMC fiscal year ending June 30, 2010

- Medicare – $236 million
- Medicaid – $209 million
- Charity Care – $155 million
- Inpatient Revenue – $1.015 million
- Outpatient Revenue – $418 million
- Total Patient Services Revenue – $1.432 million
- Total Operating Revenue – $767 million

FY 2011 King County Budget

- HMC - Sexual Assault Survivor Services: $127,627
- HMC - Building Repair & Remodel: $10,221,299 (Capital)
- Jail Health Services: $24,722,964 (GF; not listed as revenue to HMC)
- Jail Health Services (Mental Health & Drug Dependency): $3,250,372

Background Information
Health Care District of Palm Beach County (HCDPB), West Palm Beach, FL

Legal Structure, Governance, and Mission

Ownership: Health care district

Governance change: The Palm Beach County Health Care District (HCDPB) was created by Chapter 87-450, Laws of Florida, as amended, and approved by voter referendum in 1988 as a county-wide health care district to provide comprehensive planning, funding, and coordination of health care delivery for indigent and medically needy residents of Palm Beach County. The referendum provided authority for ad valorem millage rate of up to 3 mils; in 2010, the millage rate was 1.1451.

Governance: Health Care District Board of Commissioners

Operation: Health care district

Mission: Ensure access to a comprehensive health care system and the delivery of quality services for the residents of Palm Beach County.

- Saving lives in the "Golden Hour" through the integrated Trauma System
- Covering the uninsured with programs such as Vita Health and Maternity Care
- Keeping children healthy by staffing registered nurses in the public schools
- Offering skilled nursing care at the Edward J. Healey Rehabilitation and Nursing Center
- Providing acute care in underserved areas through Lakeside Medical Center on the southern shores of Lake Okeechobee

Beds: 70

Employees: 1,000 total

Clinics: None directly operated by HCDPB

Sunshine and Sovereign Immunity

Sunshine: Yes Sovereign Immunity: Yes, but only at District owned facilities

Hospital or Health System: Health System

- Integrated Trauma System
  - Two Level II trauma centers (Tenet owned and operated, St. Mary's Medical Center & Delray Medical Center). These are paid to maintain staff and service levels required to maintain "trauma" designation, and then also reimbursed for "eligible" trauma patients.
  - Air ambulances
- Uninsured with programs, such as Vita Health and Maternity Care These operate like health plans, reimbursing hospitals and doctors for services rendered to "eligible" patients.
- Registered nurses in public schools
- Skilled nursing care at the Edward J. Healey Rehabilitation and Nursing Center
- Acute care in underserved areas through Lakeside Medical Center on the southern shores of Lake Okeechobee

Board and Autonomy: HCDPB Board of Commissioners (7)

- 3 members of the Board are appointed by the County's Board of County Commissioners
- 3 members of the Board are appointed by the Governor of the State of Florida
- 1 member is the Director of the State's Department of Health for Palm Beach County
- Maximum of two consecutive 4-year terms

Background Information
Health Care District of Palm Beach County (HCDPB), West Palm Beach, FL

Financial Relationship with County/City: Independent taxing district.

Budget Approval
- Operating: HCDPB Board of Commissioners Capital: HCDPB Board of Commissioners
- Referendum that established HCDPB in 1988 authorized levying up to 3 mils in ad valorem taxes.

Assets
- Land and construction in progress: $35 million
- Depreciable capital assets, net of accumulated depreciation: $71.73 million

Teaching Hospital: Yes

Independence: Yes

Medical Staff
- Staffing: about 80
- Physicians' compensation for indigent care: Yes
- Physicians' compensation for teaching: Yes

Unions : No.

Unfunded Care
- How funded, percent funded, & limits: HCDPB is the agency that funds indigent care.
- Contract with local government to fund indigent care: HCDPB is the agency that funds indigent care.
- Federal and/or state funding: Yes

Payor Mix

Governmental Funds	Enterprise (Proprietary) Funds
68% Ad Valorem Taxes	38.5% Charges for Services-Lakeside Medical Center
32% Other, which consists of the following:	28.9% Charges for Services-Healthy Palm Beaches
5.7% Grants	17.3% Operating Grants
4.4% Investments/Other	10.0% Charges for Services-Healey Center
21.9% Charges for Services	5.3% Interest and Other

Revenues
HCDPB fiscal year ending September 30, 2010 (per HCDPB 2010 CAFR)

	Governmental Funds	Proprietary (Enterprise) Funds	Total Revenues
Ad Valorem Taxes	$155,579,316		
Intergovernmental	$9,130,674		
Charges for services	$3,438,200		
Capital Grant	$915,000		
Investment and Other Income	$7,794,477		
Total Governmental Revenues			$176,857,667
Net Patient Service Revenues		$55,701,061	
Other, Net		$2,822,338	
Total Proprietary (Operating) Revenues			$58,523,399
Total Governmental and Proprietary Revenues			$235,381,066

Expenses
HCDPB fiscal year ending September 30, 2010 (per HCDPB 2010 CAFR)
- Total Governmental Expenses: $150 million
- Total Proprietary (Operating) Expenses: $82 million

Loss from Operations (per HCDPB 2010 CAFR, the operating loss is from the proprietary funds):
- $24 million

Background Information
Tampa General Hospital (TGH), Tampa, FL

Legal Structure, Governance, and Mission

Ownership: Private non-profit (Florida Health Sciences Center, Inc., d.b.a. Tampa General)
Governance: TGH Board of Directors
Governance Change:

- From hospital authority to a new non-profit under terms of a lease (1997)
- *The Hillsborough County Hospital Authority is created and governed by Special Act of the legislature, Chapter 96-449, Laws of Florida, as amended. Until October 1, 1997, the Authority owned and operated Tampa General Hospital. On October 1, 1997, Florida Health Sciences Center, Inc., assumed responsibility for owning and operating Tampa General Hospital pursuant to a Lease Agreement entered into with the Authority. Since the Authority no longer operates the hospital, its mission has evolved into a monitoring role in connection with the Lease and a commitment to the provision of health services to indigent citizens of Hillsborough County.*[1]

Operation: Private non-profit
Mission: *TGH is the area's only level I trauma center and one of just four burn centers in Florida. With five medical helicopters we are able to transport critically injured or ill patients from 23 surrounding counties to receive the advanced care they need. The hospital is home to one of the leading organ transplant centers in the country, having performed more than 6,000 adult solid organ transplants, including the state's first successful heart transplant in 1985. TGH is a state-certified comprehensive stroke center, and its 32-bed Neuroscience Intensive Care Unit is the largest on the west coast of Florida. Other outstanding centers include cardiovascular, orthopedics, high risk and normal obstetrics, urology, ENT, endocrinology, and the Children's Medical Center, which features a nine-bed pediatric intensive care unit and one of just three outpatient pediatric dialysis units in the state. As the region's leading safety net hospital, Tampa General is committed to providing area residents with excellent and compassionate health care ranging from the simplest to the most complex medical services.*[2]
Beds: 1,004 total beds (945 acute care and 59 rehabilitation care beds)
Employees: 6,700
Clinics: ?

Sunshine and Sovereign Immunity

Sunshine: Yes Sovereign Immunity: ?

Hospital or Health System: Hospital

Board and Autonomy: 15 member, volunteer Board of Directors

Financial Relationship with County/City: TGH receives patients funded by the Hillsborough County ½ cent sales tax. That tax was authorized by the Legislature at the same time Miami-Dade's was, However, at the county level it was implemented through extraordinary vote of the then County Commission, and used to create the HC Health Care Plan. TGH is one, but not the only hospital in the Plan's provider network.

[1] Extract from Hospital Authority Non-Binding Request for Information (RFI) For Funding Opportunities Related to Health Related Services for Indigent Residents, dated February 2, 2007
[2] Extract from TGH website, http://www.tgh.org/index.htm

Background Information
Tampa General Hospital (TGH), Tampa, FL

Budget Approval
- Operating: TGH Board of Directors
- Capital: ?

Teaching Hospital: Yes, academic. TGH is affiliated with the University of South Florida College Of Medicine and serves as the primary teaching hospital for the university.

Independence: *The Authority does not operate, manage or oversee the operations of TGH, and has had no claims since leasing the hospital facilities to FHSC.*[3]

Medical Staff
- Staffing: 1200 Community and university affiliated physicians
  285 Resident physicians
- Physicians' compensation for indigent care: ?
- Physicians' compensation for teaching: ?

Unions: Not unionized

Unfunded Care (2009 Annual Report)
- How funded, percent funded, & limits: Medicaid 14%, HCHCP 3%, Charity 7%
- Indigent care: $917 million

CARE PROVIDED TO INDIGENT PATIENTS	2009	as a % of total	2008	as a % of total	2007	as a % of total
Charges Foregone						
Medicaid	$545,186	14%	$429,226	13%	$348,077	12%
HCHCP	120,281	3%	101,789	3%	94,855	3%
Charity	251,159	7%	230,786	7%	187,672	7%
Total Indigent	$916,626	24%	$761,801	24%	$630,604	22%
Hospital Gross Charges	$3,789,550		$3,201,371		$2,832,205	

Payor Mix (2009 Annual Report)
- Managed care: 39.5%
- Medicare: 27.3%
- Medicaid & Hillsborough County Health Plan: 18.0%
- All other: 15.2%

Revenues (2009 Annual Report) – TGH fiscal year ending September 30, 2009
- Medicare $545 million
- Medicaid and Hillsborough County Health Plan $128 million
- Charity Care $251 million
- Total Revenue $993 million

[3] Extract from Hospital Authority Request for Quotations For Not-For-Profit Individual and Organization Directors and Officers Liability Insurance Coverage for the Hillsborough County Hospital Authority

Background Information
Truman Medical Centers (TMC), Kansas City, MO

Legal Structure, Governance, and Mission

Ownership/Operation: Not-for-profit 501(c)(3)
Governance: Board of Directors
Governance change:

- Incorporated as Kansas City General Hospital and Medical Center in 1962, one of the first public hospitals to restructure as not-for-profit
- Renamed Truman Medical Center, Inc. in 1976

Mission: Provide accessible, state of the art healthcare to Jackson County regardless of one's ability to pay.
Beds: See attached "Truman Medical Centers Snapshot" (provided by TMC)
Employees: 4,310

Sunshine and Sovereign Immunity

- Sunshine: No
- Sovereign Immunity: No

Hospital or Health System: Health System

- Two adult acute care hospitals (TMC Hospital Hill and TMC Lakewood)
- TMC Behavioral Health
- Jackson County Health Department
- Primary care practices throughout Eastern Jackson County

Board and Autonomy

- Up to 34 members on the Board of Directors
- Nomination and selection process: Board Development Committee nominates for full Board approval
- TMC Board has autonomy from the City/County governments

Financial Relationship with County/City

- Approximately 8.5% of operating revenues come from the City of Kansas City and Jackson County
- Jackson County: FY 2009-10 adopted County budget included:
  - Indigent Health Care Subsidy: $5,429,598
  - Inmate Health Care: (none listed)
  - Debt Service: $6,847,000
- City of Kansas City: $26,403,075 (FY 2009-10 adopted City budget)
  - Note: City of Kansas City has a "Health Levy" special revenue fund budgeted at $53,580,838 that primarily consists of $50 million from property taxes and $3 million from service charges

Budget Approval

- Operating: TMC Board approves
- Capital: City/County sometimes, such as when TMC utilizes Jackson County bonds for capital needs

Assets: County owns land and some buildings; TMC owns equipment. TMC can buy/sell/encumber real property and facilities.

Background Information
Truman Medical Centers (TMC), Kansas City, MO

Bonds: Can issue bonds, but TMC reports it can be challenging in this economic environment.

Teaching Hospital: Yes; primary teaching hospital for the University of Missouri-Kansas City School of Medicine.

Independence: Human resources and procurement are independent of government

Medical Staff: 515; some physicians are employed by TMC, but the majority of physicians are affiliated with a multi-specialty group practice that provides medical care exclusively to TMC.

Unions: Yes. TMC Board has authority to determine salaries and compensation for employees, executives and physicians employed directly.

Contracting Authority: Yes

Unfunded Care: City, County, and Disproportionate Share Hospital funding
- Charity Care: $87,623,480
- Bad Debt: $13,376,520

Payor Mix

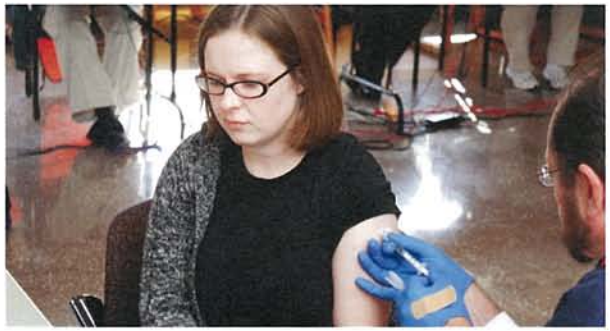
Payor Source	Acute Care Hospitals	Hospita Hill	Lakewo	Lakewood Care Center	Jackson County Health Department
Commercial	16%	14%	22%	<1%	5%
Medicaid	22%	26%	16%	71%	41%
Medicaid MC	14%	11%	20%	-	-
Medicare	16%	17%	12%	<1%	7%
Other	3%	3%		12%	
Self pay	29%	29%	30%	16%	10%
Government	-	-	-	-	33%
Managed Care	-	-	-	-	4%

Patient Diversity

Ethnicity	Acute Care Hospitals	Hospital Hi	Lakewood	Lakewood Care Center	Jackson County Health Department
African American	36%	32%	17%	16%	10%
Asian	1%	4%	1%	-	2%
Caucasian	51%	59%	73%	3%	82%
Hispanic	7%	3%	5%	6%	5%
Other	5%	2%	4%	-	-
American Indian	-	-	-	-	1%

Truman Medical Centers Snapshot

Preventive Care



Mammograms Administered	7,206
Hospital Hill	5,154
Lakewood	2,106

Immunizations Administered	39,849
to TMC Patients	14,351
to TMC Employees	4,758
by Jackson County Health Dept.	20,740

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Health & Wellness

Employees	4,310
Hospital Hill	3,180
Lakewood	1,130
Employee Health Assessments	2,805
Percentage of Employees Assessed	64%
Employee Absenteeism Days	Calendar Year 2009
Family Medical Leave	4,488
Short Term Disability	4,412
Corporate Academy Course Admissions	
Employees enrolled	779
Classes enrolled	2,697

Healthy Harvest Encounters	5,488
Hospital Hill	4,803
Lakewood	685
Pounds of Produce Sold at Markets	60,166
Hospital Hill	52,833
Lakewood	7,333

Quality Outcomes

Patient Re-Admissions within 30 days	
Hospital Hill	8.69%
Lakewood	2.67%

Quality Improvement	
Reduction in Patient Falls	28%
Reduction in Patient Pressure Ulcers	32%

CPOE/Meaningful Use	93%*

Computerized Physician Order Entry
*= based on preliminary data for both TMC hospitals

Medical Home Chronic Patients	15,592
	Calendar Year 2009
Asthma	1601
Congestive Heart Failure	509
COPD (Chronic Obstructive Pulmonary Disease)	940
Diabetes	4,737
GERD (Esophagal Reflux)	911
Hypertension	6,330
Obesity	450
Sickle Cell	114

Truman Medical Centers Snapshot

Fiscal Year Ending June 30, 2010*

	Hospital Hill	Lakewood	Total
Licensed Beds			
Acute Care	277	103	380
Long Term Care	-	212	212
Admissions			
Acute Care[1]	16,612	4,562	21,174
Patient Days			
Acute Care[1]	73,512	20,305	93,817
Long Term Care	-	57,361	57,361
Average Daily Census			
Acute Care[1]	201	56	257
Long Term Care	-	157	157
Births	2,325	973	3,298
Outpatient Visits	210,853	95,802	306,655
Emergency Department Visits[2]	68,039	30,845	98,884
Surgical Cases[3]	7,720	2,257	9,977
Dental/Oral Surgery Visits[4]	8,297	17,957	26,254
Jackson County Health Department Encounters	-	-	187,831
Women/Infant/Children (WIC) Visits	64,344	115,622	179,966
Number of Unduplicated Patients	62,757	36,899	99,656
Commercially Insured Patients	10,647	9,097	19,744
Medical Staff	-	-	515
Graduate Medical Residents	144	50	194

1 Includes Neonatal Intensive Care Unit.
2 Hospital Hill includes Behavioral Health emergency visits. Does not include 675 defined trauma cases.
3 Includes Cesarean Sections.
4 Included in total outpatient visits.
5 Included in Hospital Hill Acute Care Admissions.

Behavioral Health	
Number of Patients	16,170
Admissions[5]	2,758
Outpatient Visits	240,858

Uncompensated Care at Cost	
Bad Debt	$12,296,406
Charity Care	$95,993,105
Total	$108,289,511

Fiscal Year 2010 Revenue	
Gross Revenue	$594,002,000
Net Revenue	$438,279,000

*** All numbers are preliminary/unaudited.**

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Hospital Governance Options

Governance Models	Governance Description	Characteristics		Example of Hospitals	Location	Effective Date of Governance Model	Links to References	Type of Change	Notes	Other Variables	
										Teaching Hospital (Y/N)	Organized Labor union (Y/N)
Direct Local Government Control/Operation	- Major decisions made by elected officials; -May designate operations to semi-autonomous board; - Have access to local gov't tax support; - No separate legal structure	-Is current structure and has worked since the 1970's; -Should provide base of political support for advocacy initiatives; -Full faith and credit of county gov't to underpin bonding; -Sovereign immunity applies to those employed by JHS; -Sole beneficiary of ad valorem property taxes earmarked for indigent care; -Exempt from taxes	-Levels of autonomy for PHT vary based on leadership both at Trust and on Commission; -dependent upon gov't purchasing and personnel policies and procedures; -Sunshine law provisions occasionally hamper internal communications; -county can delegate programs/services and over-ride PHT decisions	John H Stroger Jr. Hospital Cook County	Chicago , IL					Y	Y
				Los Angeles County Dept of Health Services	Los Angeles County, CA					Y	Y
				Jackson Health System	Miami Dade County, FL					Y	Y
Separate Government Entity With Taxing Capacity	-Distinct independent government entity; -Functionally dedicated board; -Statutory authority identifies election/appointment process; -Controls own budget, issues bonds; -Has autonomy in civil service, purchasing and contracting	-Sets own millage rates; -Has both authority and responsibility for use of public funds; -Still has some political ties based on way legislation is written and board is elected/appointed; -Has sovereign immunity as unit of gov't; -Develops and adopts own policies and procedures and labor agreements; -Tax exempt	-Subject to Sunshine law; funding levels vary based on economy and property values; -Board members have high public/political profile; -have to use own credit status to raise capital; -not eligible for philanthropy	Memorial Health Care System (South Broward) & Broward Health (North Broward Hospital District)	Broward County, FL	1947 & 1951		Taxing District		Y	?
				Parkland Health & Hospital System	Dallas, TX					Y	?
				University of Colorado Hospital	Colorado	1991	6	Established new (Independent) hospital authority		Y	N
				Denver Health Medical Center	Denver, CO	1996	2			Y	N
Nonprofit/Third Party Management	-Tax exempt under Sect. 501(c)(3) of IRS; -Local gov't may maintain some role in governance (eg seat on, or appointment to, board) and/or funding (pay for specified services to specified patients); -Sale, transfer or long term lease of buildings/assets of gov't; -Third party controls operations including human resources, purchasing and contracts	-Eligible recipient for philanthropy without using separate foundation; -Not required to have organized labor; -Can develop and implement own policies and procedures for nomination and selection of board of directors, purchasing and contracts; -Exempt from income, property and sales taxes on all "related" revenue	-No longer only hospital designated eligible for County funding for indigent care; -Must create and maintain own credit rating; -No sovereign immunity; -Have to compete with other community based organizations for talented board leadership and local philanthropy; - "Non-related" revenue subject to taxation	Boston Medical Center	Boston, MA	1996	1, 6			Y	Y
				Great Lakes Health System of Western New York	Buffalo, NY	2008	1		Unified Kaleida Health and the Eric County Medical Center into a new non-profit (unification continues)	Y	Y
				Fresno County Valley Medical Center	Fresno County, CA	1996	1	Consolidated with existing non-profit		Y	N
				Oakwood Healthcare System	Dearborn, MI	1991	6			Y	Y
				Shands Jacksonville	Jacksonville, FL	1980	1			Y	Y
				Umass Memorial Health Care System	Massachusetts	1998	1			Y	Y
				Middle Tennessee Medical Center	Murfreesboro, TN	1996	5			N	N
				University of Arizona Healthcare	Tucson, AZ	2010	1			Y	?
				Grady Health System	Atlanta, GA	2008	1,3	Conversion to new non-profit		Y	N
				Truman Medical Centers	Kansas City, MO	1960s	1			Y	Y
				Regional Medical Center at Memphis	Memphis, TN	1981	1			Y	N
				Hillsborough County Hospital Authority / Tampa General Hospital	Tampa, FL	1997	1,4			Y	N
				Brackenridge Hospital and Children's Hospital	Austin, TX	1995	1,6	Contract management by non-profit 3rd Party		Y	?
				Harborview Medical Center	King County, WA					Y	Y
				Sutter Medical Center of Santa Rosa, California	Santa Rosa, CA	1996	6			Y	Y
				Wishard Memorial Hospital	Indianapolis, IN					?	?
				Henry Ford Hospital	Michigan, MI	1987	7	Shared Governance	Non-profit hospital adopted "shared governance" model	Y	?
				Nebraska Medical Center	Omaha, NE		1			Y	Y
For-Profit Management	Managed as a private organization			Amarillo Hospital District	Amarillo, TX						
				Detroit Medical Center/Vanguard Health Systems	Detroit, MI	2010			Acquired by Vanguard Health Systems	Y	Y
				Caritas Christi/Steward Health Care System	Massachusetts	2010	1		Acquired by Steward Health Care System LLC	Y	Y
				Memorial Medical Center	Las Cruces, NM					?	?
				Oklahoma University Medical Center	Oklahoma City, OK					?	?

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South Florida Acute Care Hospitals
(Federal, State and Local Funding Sources)

Financial Analysis ~ Hospitals in South Florida ~ FY2009

Source: AHCA Financial Data, FYE2009

Hospital	County	Beds	Total Expenses	Medicaid Revenue	Medicaid Deductions	Medicaid HMO Revenue	Medicaid HMO Deductions	Bad Debt	Other Charity	Medicaid Shortfall	PMATF	Total	Other Gov't. Funds	Net Uncompensated Care	Taxes & Licenses Expense	Inpatient Services Revenue	Outpatient Services Revenue	Total Patient Services Revenue
Broward Health-Broward General Medical Cer	Broward	716	$399,777,301	$266,150,135	$206,572,325	$191,494,893	$146,654,079	$170,477,277	$216,647,512	$248,032,493	$4,294,012	$639,451,294	$71,683,906	$567,767,388	$0	$1,144,374,602	$594,852,434	$1,739,227,036
Broward Health-Coral Springs Medical Center	Broward	200	$128,088,074	$44,775,133	$32,981,867	$38,197,866	$30,029,079	$59,320,206	$31,333,199	$44,797,177	$1,522,887	$136,973,469	$13,018,541	$123,954,928	$0	$322,190,710	$261,315,739	$583,506,449
Broward Health-Imperial Point Medical Center	Broward	204	$92,840,031	$17,392,320	$13,320,949	$17,457,309	$13,187,005	$37,820,461	$14,556,142	$18,606,242	$1,044,567	$72,027,412	$8,703,089	$63,324,323	$0	$215,351,477	$194,109,233	$409,460,710
Broward Health-North Broward Medical Center	Broward	409	$184,208,777	$43,737,776	$36,054,756	$43,968,435	$34,754,655	$86,929,623	$77,820,692	$49,973,881	$2,120,591	$216,844,787	$31,152,713	$185,692,074	$0	$514,236,684	$261,181,753	$775,418,437
Cleveland Clinic Florida Weston	Broward	150	$146,040,609	$6,887,777	$7,765,197	$6,068,950	$6,842,063	$13,303,444	$3,114,209	$11,718,945	$2,512,081	$30,648,679	$0	$30,648,679	$504,970	$398,929,626	$256,195,653	$655,125,279
Holy Cross Hospital	Broward	571	$292,912,751	$44,131,585	$40,685,046	$23,927,801	$21,559,508	$32,782,676	$12,162,135	$49,080,894	$3,239,915	$97,265,620	$0	$97,265,620	$151,981	$912,015,323	$602,416,229	$1,514,431,552
Memorial Hospital Miramar	Broward	178	$116,186,272	$56,164,393	$42,782,501	$20,276,421	$14,550,374	$33,107,418	$15,269,042	$41,300,586	$1,697,811	$91,374,857	$1,268,889	$90,105,968	$0	$285,739,857	$268,228,032	$553,967,889
Memorial Hospital Pembroke	Broward	301	$108,585,529	$40,420,559	$34,723,325	$24,499,093	$19,611,793	$41,247,087	$47,865,488	$41,276,212	$1,331,039	$131,719,826	$3,083,538	$128,636,288	$0	$267,285,655	$272,524,838	$539,810,493
Memorial Hospital West	Broward	304	$297,242,934	$107,649,986	$87,411,368	$43,546,785	$32,478,240	$59,820,066	$60,861,496	$87,386,834	$4,174,049	$212,242,445	$4,743,987	$207,498,458	$0	$770,072,940	$612,645,096	$1,382,718,036
Memorial Regional Hospital	Broward	1014	$697,303,144	$356,605,670	$276,077,600	$151,474,864	$107,844,957	$162,862,602	$256,541,519	$251,900,344	$8,128,944	$679,433,409	$46,673,341	$632,760,068	$0	$1,658,347,286	$1,025,187,148	$2,683,534,434
North Shore Medical Center FMC Campus	Broward	459	$53,990,779	$27,175,727	$23,175,552	$15,917,542	$14,405,563	$5,073,566	$8,802,290	$30,880,416	$726,932	$45,483,204	$0	$45,483,204	$296,066	$263,276,125	$83,947,207	$347,223,332
Northwest Medical Center	Broward	215	$128,484,935	$51,622,041	$47,990,764	$27,106,725	$25,057,053	$22,322,186	$18,386,647	$59,960,590	$1,690,354	$102,359,777	$0	$102,359,777	$890,158	$548,652,866	$224,273,306	$772,926,172
Plantation General Hospital	Broward	264	$119,453,613	$168,822,515	$137,175,717	$91,947,684	$86,235,030	$34,135,272	$14,524,632	$174,489,126	$1,561,499	$224,710,529	$0	$224,710,529	$518,740	$467,676,544	$169,055,069	$636,731,613
University Hospital & Medical Center	Broward	317	$91,658,269	$18,636,754	$16,615,370	$21,063,368	$18,546,623	$19,790,486	$10,324,581	$28,284,151	$1,048,139	$59,447,357	$0	$59,447,357	$809,261	$357,261,255	$171,806,530	$529,067,785
Westside Regional Medical Center	Broward	224	$145,309,379	$28,494,868	$25,951,670	$21,348,629	$18,539,828	$24,025,883	$12,016,752	$36,078,062	$2,145,256	$74,265,953	$0	$74,265,953	$668,972	$663,319,410	$197,533,151	$860,852,561
Total Acute			**$3,002,082,397**	**$1,278,667,239**	**$1,029,284,007**	**$738,296,365**	**$590,295,850**	**$803,018,253**	**$800,226,336**	**$1,173,765,954**	**$37,238,076**	**$2,814,248,619**	**$180,328,004**	**$2,633,920,615**	**$3,840,148**	**$8,788,730,360**	**$5,195,271,418**	**$13,984,001,778**
Aventura Hospital and Medical Center	Miami-Dade	407	$199,924,435	$70,575,301	$66,209,722	$42,461,009	$37,642,480	$31,102,540	$28,560,835	$85,683,244	$2,944,795	$148,291,414	$0	$148,291,414	$2,499,926	$959,794,848	$284,014,538	$1,243,809,386
Baptist Hospital of Miami, Inc.	Miami-Dade	680	$725,970,825	$330,422,385	$266,603,341	$78,587,674	$67,905,584	$97,797,245	$122,290,683	$235,576,068	$10,927,756	$466,591,752	$0	$466,591,752	$314,587	$2,031,315,918	$970,006,179	$3,001,322,097
Bascom Palmer Eye Inst/Anne Bates Leach Ey	Miami-Dade	100	$81,532,460	$21,082,622	$17,006,357	$7,541,688	$4,323,030	$7,053,281	$13,333,215	$12,690,595	$769,079	$33,846,170	$0	$33,846,170	$0	$4,183,304	$265,971,418	$270,154,722
Coral Gables Hospital	Miami-Dade	247	$71,537,971	$31,695,974	$27,564,658	$17,063,934	$15,369,984	$5,366,050	$6,396,735	$34,532,883	$973,613	$47,269,281	$0	$47,269,281	$1,316,960	$292,125,061	$123,048,114	$415,173,175
Doctors Hospital	Miami-Dade	281	$160,508,157	$21,304,202	$19,515,192	$6,844,316	$6,126,847	$22,598,747	$6,035,783	$18,753,621	$1,903,249	$49,291,400	$0	$49,291,400	$15,740	$403,780,540	$252,112,663	$655,893,203
Hialeah Hospital	Miami-Dade	378	$107,864,993	$148,656,137	$129,741,980	$30,513,768	$26,505,698	$17,227,613	$15,495,068	$129,397,190	$1,627,400	$163,747,271	$0	$163,747,271	$1,450,599	$567,176,508	$152,592,928	$719,769,436
Homestead Hospital	Miami-Dade	142	$188,573,857	$110,648,137	$91,937,469	$70,137,151	$52,267,018	$78,745,135	$74,763,187	$97,776,128	$2,084,598	$253,369,048	$0	$253,369,048	$37,942	$449,510,079	$284,769,144	$734,279,223
Jackson Memorial Hospital	Miami-Dade	2139	$1,625,681,833	$943,808,545	$529,203,251	$262,543,000	$126,020,640	$583,901,326	$1,073,847,090	$188,325,532	$15,065,601	$1,861,139,549	$350,277,832	$1,510,861,717	$0	$3,038,363,518	$1,162,002,054	$4,200,365,572
Kendall Regional Medical Center	Miami-Dade	412	$191,858,307	$174,811,568	$153,027,526	$52,581,811	$44,979,055	$35,292,503	$44,961,553	$163,382,784	$2,809,636	$246,446,476	$0	$246,446,476	$2,109,453	$865,057,331	$394,980,936	$1,260,038,267
Larkin Community Hospital	Miami-Dade	132	$46,816,961	$16,636,446	$14,106,718	$5,751,057	$3,593,144	$6,020,243	$561,497	$11,825,678	$655,962	$19,063,380	$0	$19,063,380	$531,621	$142,788,747	$35,638,549	$178,427,296
Mercy Hospital	Miami-Dade	473	$234,672,696	$61,097,616	$56,319,256	$17,049,781	$15,939,508	$19,321,565	$12,445,322	$54,955,284	$2,965,239	$89,687,410	$0	$89,687,410	$33,574	$705,571,281	$354,276,800	$1,059,848,081
Metropolitan Hospital of Miami	Miami-Dade	146	$46,288,089	$25,043,369	$20,159,081	$0	$0	$16,768,725	$99,625	$14,124,713	$600,620	$31,593,683	$0	$31,593,683	$547,466	$138,085,635	$54,015,624	$192,101,259
Miami Children's Hospital	Miami-Dade	289	$340,523,656	$426,684,995	$320,968,472	$197,475,385	$150,474,804	$9,618,075	$7,232,337	$262,755,861	$4,539,407	$284,145,680	$0	$284,145,680	$4,539,407	$635,655,178	$382,812,439	$1,018,467,617
Mount Sinai Medical Center	Miami-Dade	955	$397,617,953	$111,730,059	$91,269,602	$38,198,600	$29,588,019	$47,560,082	$34,611,498	$86,454,270	$4,490,018	$173,115,868	$0	$173,115,868	$60,973	$1,086,947,815	$645,857,994	$1,732,805,809
North Shore Medical Center	Miami-Dade	816	$204,812,283	$166,451,296	$135,360,669	$97,729,018	$80,824,519	$17,470,126	$44,363,445	$170,087,485	$2,828,734	$234,749,790	$0	$234,749,790	$2,734,627	$809,135,978	$364,618,250	$1,173,754,228
Palm Springs General Hospital	Miami-Dade	247	$61,119,424	$11,756,420	$9,716,561	$0	$0	$18,104,151	$0	$6,289,578	$949,988	$25,343,717	$0	$25,343,717	$515,252	$148,187,851	$61,485,086	$209,672,937
Palmetto General Hospital	Miami-Dade	360	$215,790,253	$213,747,432	$185,600,500	$74,053,078	$63,001,735	$17,091,947	$30,883,066	$201,383,086	$3,176,351	$252,534,450	$0	$252,534,450	$2,413,474	$951,384,171	$363,856,505	$1,315,240,676
South Miami Hospital	Miami-Dade	467	$393,692,061	$156,205,546	$124,886,036	$20,270,389	$18,229,070	$44,290,002	$42,831,569	$96,768,937	$5,891,230	$189,781,738	$0	$189,781,738	$241,525	$890,373,409	$608,718,669	$1,499,092,078
University of Miami Hospital	Miami-Dade	560	$265,977,251	$95,266,975	$83,604,967	$48,931,889	$40,388,829	$24,082,731	$16,151,329	$92,036,405	$2,566,301	$134,836,766	$0	$134,836,766	$44,572	$994,225,875	$205,922,716	$1,200,148,591
University of Miami Hospital/Clinics	Miami-Dade	40	$238,592,419	$38,690,052	$32,820,901	$14,278,675	$11,923,510	$7,991,767	$1,098,159	$29,483,875	$2,188,091	$40,761,892	$0	$40,761,892	$0	$90,763,420	$737,381,602	$828,145,022
Westchester General Hospital	Miami-Dade	197	$59,787,906	$17,005,536	$13,754,777	$13,362,545	$6,884,087	$2,591,247	$6,305,408	$9,433,359	$861,219	$19,191,233	$0	$19,191,233	$738,855	$138,473,844	$23,557,582	$162,031,426
Total Acute			**$5,859,143,790**	**$3,193,320,613**	**$2,389,377,036**	**$1,095,374,768**	**$801,987,561**	**$1,109,995,101**	**$1,582,267,404**	**$2,001,716,578**	**$70,818,887**	**$4,764,797,970**	**$350,277,832**	**$4,414,520,138**	**$20,146,553**	**$15,342,900,311**	**$7,727,639,790**	**$23,070,540,101**
Bethesda Healthcare System	Palm Beach	401	$223,349,147	$189,069,432	$158,031,194	$44,430,241	$34,561,136	$49,297,011	$46,948,922	$150,738,408	$0	$246,984,341	$0	$246,984,341	$2,673,217	$772,120,498	$473,926,480	$1,246,046,978
Boca Raton Community Hospital	Palm Beach	400	$332,151,151	$15,621,633	$17,684,584	$4,418,709	$3,752,109	$25,689,849	$4,518,806	$16,719,600	$3,376,742	$50,304,997	$0	$50,304,997	$196,098	$614,106,542	$797,021,504	$1,411,128,046
Columbia Hospital	Palm Beach	250	$87,791,014	$35,310,722	$31,172,164	$24,194,631	$20,829,371	$25,892,580	$24,738,917	$40,804,539	$1,061,704	$92,497,740	$0	$92,497,740	$1,023,415	$313,365,492	$153,191,349	$466,556,841
Delray Medical Center, Inc.	Palm Beach	493	$224,363,202	$63,122,815	$58,723,239	$17,522,293	$15,993,859	$16,630,452	$28,323,348	$61,921,591	$3,353,631	$110,229,022	$5,495,933	$104,733,089	$2,897,640	$1,098,329,238	$315,744,813	$1,414,074,051
Good Samaritan Medical Center	Palm Beach	333	$108,760,037	$33,984,426	$29,527,271	$16,873,107	$14,775,956	$11,410,367	$16,000,759	$32,918,899	$1,383,869	$61,713,894	$0	$61,713,894	$1,798,041	$311,592,895	$174,273,928	$485,866,823
JFK Medical Center	Palm Beach	460	$354,422,045	$180,823,249	$164,638,302	$55,894,321	$43,363,838	$50,040,043	$100,415,320	$169,230,862	$5,001,084	$324,687,309	$0	$324,687,309	$1,973,085	$1,566,768,614	$597,150,895	$2,163,919,509
Jupiter Medical Center	Palm Beach	163	$157,196,823	$15,456,684	$12,224,521	$4,540,561	$4,092,313	$17,988,227	$4,156,991	$12,050,296	$1,965,186	$36,160,700	$0	$36,160,700	$470,971	$388,154,854	$348,625,963	$736,780,817
Lakeside Medical Center (Glades General Hos	Palm Beach	73	$36,803,379	$28,808,762	$23,538,178	$0	$0	$8,846,290	$3,564,576	$14,031,127	$78,644	$26,520,637	$8,450,000	$18,070,637	$7,780	$62,534,933	$48,988,583	$111,523,516
Palm Beach Gardens Medical Ctr.	Palm Beach	199	$150,336,938	$21,419,658	$19,509,646	$10,348,635	$9,116,723	$10,613,574	$22,738,593	$22,280,909	$2,119,063	$57,752,139	$0	$57,752,139	$1,780,558	$587,095,244	$165,560,662	$752,655,906
Palms West Hospital	Palm Beach	175	$121,321,707	$111,081,280	$96,202,462	$29,638,996	$24,657,223	$26,560,475	$23,427,534	$97,232,084	$1,631,603	$148,851,696	$0	$148,851,696	$1,040,207	$470,630,103	$251,932,650	$722,562,753
St. Mary's Medical Center	Palm Beach	463	$216,586,513	$287,240,660	$230,279,632	$72,031,143	$59,401,505	$25,113,855	$99,976,470	$213,182,936	$3,067,029	$341,340,290	$4,853,450	$336,486,840	$2,992,926	$738,639,640	$278,553,260	$1,017,192,900
Wellington Regional Medical Center	Palm Beach	143	$120,458,701	$58,005,521	$50,029,130	$17,925,295	$15,024,409	$23,037,907	$22,470,599	$48,330,730	$1,532,944	$95,372,180	$0	$95,372,180	$2,217,351	$335,320,186	$211,629,044	$546,949,230
West Boca Medical Center, Inc.	Palm Beach	195	$109,147,083	$49,951,663	$43,399,971	$16,496,804	$13,235,138	$10,738,904	$6,267,613	$40,876,991	$1,870,941	$59,754,449	$0	$59,754,449	$1,768,602	$315,630,296	$144,618,605	$460,248,901
Total Acute			**$2,242,687,740**	**$1,089,896,505**	**$934,960,294**	**$314,314,736**	**$258,803,580**	**$301,859,534**	**$403,548,448**	**$920,318,972**	**$26,442,440**	**$1,652,169,394**	**$18,799,383**	**$1,633,370,011**	**$20,839,891**	**$7,574,288,535**	**$3,961,217,736**	**$11,535,506,271**

South Florida Acute Care Hospitals
(Federal, State and Local Funding Sources)

Financial Analysis ~ Hospitals in South Flori											
Source: AHCA Financial Data, FYE2009											
Hospital	County	Other Operating Revenue	Non- operating Revenue	Total Revenue	Income Tax	Licensed Beds	Acute Pt. Days	Salary Expense	FTEs	Pt. Care Salary Expense	Pt. Care FTEs
Broward Health-Broward General Medical Cer	Broward	$35,129,834	$82,681,476	$1,857,038,346	$0	716	160,234	$163,810,417	2,930.1	$120,687,726	1,991.5
Broward Health-Coral Springs Medical Center	Broward	$2,772,866	$14,058,365	$600,337,680	$0	200	48,991	$55,417,571	937.6	$42,044,714	654.6
Broward Health-Imperial Point Medical Center	Broward	$3,099,171	$9,663,347	$422,223,228	$0	204	38,149	$38,661,347	674.0	$28,115,236	458.6
Broward Health-North Broward Medical Center	Broward	$10,167,171	$39,185,720	$824,771,328	$0	409	78,499	$77,158,160	1,317.0	$54,194,978	861.7
Cleveland Clinic Florida Weston	Broward	$532,868	$270,638	$655,928,785	$0	150	45,853	$52,105,962	922.3	$38,430,895	671.1
Holy Cross Hospital	Broward	$3,626,743	$89,478,763	$1,607,537,058	$0	571	92,964	$155,868,784	2,223.5	$68,873,263	1,095.5
Memorial Hospital Miramar	Broward	$723,994	$1,932,563	$556,624,446	$0	178	35,893	$54,987,837	847.1	$38,636,318	569.0
Memorial Hospital Pembroke	Broward	$1,394,184	$3,903,388	$545,108,065	$0	301	29,525	$50,900,482	798.9	$36,234,105	546.4
Memorial Hospital West	Broward	$3,065,705	$7,737,960	$1,393,521,701	$0	304	94,289	$140,388,956	2,170.2	$98,151,103	1,460.2
Memorial Regional Hospital	Broward	$24,687,022	$69,541,459	$2,777,762,915	$0	1,014	213,940	$340,650,430	5,060.3	$222,419,154	3,319.0
North Shore Medical Center FMC Campus	Broward	$129,352	$1,920,042	$349,272,726	$0	459	25,031	$19,099,928	322.3	$14,866,207	245.4
Northwest Medical Center	Broward	$1,196,226	$1,577,107	$775,699,505	$1,333,969	215	48,789	$41,333,009	674.2	$30,760,906	469.7
Plantation General Hospital	Broward	$1,568,584	$227,745	$638,527,942	$0	264	51,200	$38,438,149	584.3	$28,590,993	430.9
University Hospital & Medical Center	Broward	$454,115	$19,401,617	$548,923,517	$0	317	43,666	$31,501,825	558.5	$20,800,344	345.2
Westside Regional Medical Center	Broward	$1,190,422	$24,074,719	$886,117,702	-$13,018,176	224	57,172	$44,963,226	722.5	$32,725,085	494.4
Total Acute		**$89,738,257**	**$365,654,909**	**$14,439,394,944**	**-$11,684,207**	**5,526**	**1,064,195**	**$1,305,286,083**	**20,742.8**	**$875,531,027**	**13,613.2**
Aventura Hospital and Medical Center	Miami-Dade	$572,061	$3,606,105	$1,247,987,552	$0	407	97,244	$65,589,168	1,098.6	$52,852,959	836.8
Baptist Hospital of Miami, Inc.	Miami-Dade	$7,920,397	$2,193,042	$3,011,435,536	$0	680	183,544	$240,339,300	4,047.0	$186,827,638	2,971.8
Bascom Palmer Eye Inst/Anne Bates Leach Ey	Miami-Dade	$3,012,491	$3,135	$273,170,348	$0	100	656	$32,855,719	568.0	$18,320,806	287.3
Coral Gables Hospital	Miami-Dade	$339,499	$93,775	$415,606,449	$0	247	27,576	$24,673,766	430.3	$18,706,077	315.2
Doctors Hospital	Miami-Dade	$841,299	-$239,708	$656,494,794	$0	281	38,920	$54,692,402	928.1	$40,561,305	654.7
Hialeah Hospital	Miami-Dade	$960,087	$3,960,664	$724,690,187	-$3,466,000	378	55,850	$40,908,342	703.7	$32,466,782	540.9
Homestead Hospital	Miami-Dade	$1,308,122	$123,125	$735,710,470	$0	142	47,090	$64,054,360	1,069.3	$52,120,639	825.9
Jackson Memorial Hospital	Miami-Dade	$27,150,516	$581,119,005	$4,808,635,093	$0	2,139	477,435	$750,205,650	11,025.8	$465,388,097	6,313.9
Kendall Regional Medical Center	Miami-Dade	$2,623,219	$501,779	$1,263,163,265	$0	412	72,317	$62,770,753	1,089.4	$46,774,443	768.5
Larkin Community Hospital	Miami-Dade	$861,192	$111,734	$179,400,222	$0	132	29,537	$22,306,645	490.9	$14,225,079	321.7
Mercy Hospital	Miami-Dade	$6,578,249	$49,406,258	$1,115,832,588	$0	473	74,631	$87,834,283	1,515.5	$57,215,416	925.1
Metropolitan Hospital of Miami	Miami-Dade	$608,755	$13,176	$192,723,190	$0	146	23,299	$21,439,607	490.9	$15,462,153	321.4
Miami Children's Hospital	Miami-Dade	$23,840,647	$56,449,244	$1,098,757,508	$0	289	64,819	$176,759,733	2,538.6	$78,664,892	1,199.7
Mount Sinai Medical Center	Miami-Dade	$21,542,315	$1,443,551	$1,755,791,675	$0	955	138,092	$140,114,965	2,824.7	$87,624,307	1,711.0
North Shore Medical Center	Miami-Dade	$2,371,398	$4,495,457	$1,180,621,083	-$1,521,000	816	98,081	$80,589,963	1,365.6	$62,623,401	1,019.2
Palm Springs General Hospital	Miami-Dade	$568,054	$3,495,821	$213,736,812	$0	247	36,956	$26,513,423	613.5	$17,628,615	402.2
Palmetto General Hospital	Miami-Dade	$4,346,062	$1,213,287	$1,320,800,025	-$4,909,000	360	95,546	$78,141,155	1,339.3	$61,979,670	1,008.7
South Miami Hospital	Miami-Dade	$3,754,622	$967,048	$1,503,813,748	$0	467	80,838	$131,614,970	2,235.8	$102,716,580	1,626.5
University of Miami Hospital	Miami-Dade	$5,721,015	$6,312,171	$1,212,181,777	$0	560	112,918	$80,277,930	1,452.5	$58,111,088	937.9
University of Miami Hospital/Clinics	Miami-Dade	$2,652,824	$1,000	$830,798,846	$0	40	7,988	$56,941,360	960.6	$34,060,566	580.2
Westchester General Hospital	Miami-Dade	$1,074,900	$22,638	$163,128,964	$0	197	53,003	$28,839,899	663.3	$17,380,878	383.0
Total Acute		**$118,647,724**	**$715,292,307**	**$23,904,480,132**	**-$9,896,000**	**9,468**	**1,816,340**	**$2,267,463,393**	**37,451.4**	**$1,521,711,391**	**23,951.6**
Bethesda Healthcare System	Palm Beach	$2,220,479	$12,219,698	$1,260,487,155	$0	401	96,887	$88,155,335	1,764.0	$68,927,208	1,285.1
Boca Raton Community Hospital	Palm Beach	$306,026	$16,508,340	$1,427,942,412	$0	400	85,657	$110,224,545	2,004.1	$75,328,186	1,271.3
Columbia Hospital	Palm Beach	$1,604,199	$2,936,267	$471,097,307	$5,515,498	250	42,332	$27,889,473	483.1	$17,388,536	292.6
Delray Medical Center, Inc.	Palm Beach	$1,163,077	$6,969,915	$1,422,207,043	-$8,353,000	493	96,122	$79,306,213	1,342.2	$62,991,566	1,054.3
Good Samaritan Medical Center	Palm Beach	$803,640	$4,955,339	$491,625,802	$463,000	333	37,280	$37,752,440	679.5	$25,662,250	426.1
JFK Medical Center	Palm Beach	$8,823,154	$2,686,609	$2,175,429,272	-$1,800,405	460	117,000	$102,622,964	1,632.9	$79,570,212	1,222.9
Jupiter Medical Center	Palm Beach	$2,745,697	$21,112,352	$760,638,866	$0	163	47,206	$83,320,076	1,241.5	$48,487,367	673.7
Lakeside Medical Center (Glades General Hos	Palm Beach	$589,867	$8,778,578	$120,891,961	$0	73	9,795	$16,459,246	264.5	$8,960,481	150.3
Palm Beach Gardens Medical Ctr.	Palm Beach	$346,700	$1,898,395	$754,901,001	-$685,000	199	50,498	$44,061,927	718.7	$33,544,133	543.0
Palms West Hospital	Palm Beach	$2,048,769	$10,576,038	$735,187,560	-$4,060,596	175	47,329	$42,112,340	691.6	$31,592,392	493.0
St. Mary's Medical Center	Palm Beach	$5,209,594	$7,102,488	$1,029,504,982	$13,551,000	463	102,921	$92,619,357	1,445.5	$73,854,821	1,070.6
Wellington Regional Medical Center	Palm Beach	$2,490,309	$1,995,567	$551,435,106	$628,000	143	42,246	$39,199,894	703.8	$29,048,602	491.9
West Boca Medical Center, Inc.	Palm Beach	$1,240,003	$168,802	$461,657,706	-$3,217,000	195	43,151	$43,830,038	692.9	$34,434,702	538.7
Total Acute		**$29,591,514**	**$97,908,388**	**$11,663,006,173**	**$2,041,497**	**3,748**	**818,424**	**$807,553,848**	**13,664.3**	**$589,790,456**	**9,513.5**

Appendix L

Dissenting View of a Taskforce Member

Hospital Governance Task Force Dissenting Opinion

The Hospital Governance Task Force (HGT) was a unique and valuable opportunity for a diverse group of community leaders to explore, discuss, and learn more about the governance and related issues impacting Jackson Health System. The group included subject matter experts on hospital governance structures and also solicited the input on several major public healthcare systems on the strengths and weaknesses of their models. Although brief (less than 20 hours total), the task force was able to learn much on the topic and Mr. Zapata should be commended for his leadership.

Given the short duration of the task force and the lack of any legal, financial, operational, strategic or other due diligence or modeling of alternative governance models as they would impact Jackson Health System, it would be inappropriate for the task force to author any specific recommendations to the County Commissioners at this point. The governance discussion is inherently complex and therefore any change in the governance structure is a relatively long process to evaluate and implement. It is clearly not to be considered a solution for the immediate financial issues impacting Jackson. As Mr. Larry Gage, a national known hospital governance expert, reported to the task force "effective governance is a tool, not a panacea." Therefore, Jackson needs to remain focused on the very real operational and other issues currently impacting its ability to achieve sustainability in the short term.

Jackson is currently going through a major leadership transition with the hiring of a new Chief Executive Officer. In addition, the County recently approved the formation of a financial recovery board to oversee Jackson which is in the process of being populated. The financial recovery board is not a governance change, per se, as it is contemplated in ordinance 25A, but it does serve the purpose of reducing the size of the board and populating the board with subject matter experts in relevant areas of focus. These changes have great potential and should be allowed to crystallize and mature prior to introducing a further complexity of a new governance structure. This will provide Jackson the best opportunity to achieve immediate sustainability which needs to be the paramount focus. There can be no distractions from this vital objective although continued study of the optimal governance structure for Jackson is advisable.

The *National Association of Public Hospitals and Health Systems* reported that "before considering a major reorganization, it is essential to evaluate the challenges and obstacles that face a given hospital or health system – and to determine which of these challenges can be improved through improved structure or governance." The following are some operational issues that need to be addressed regardless of the governance structure:

- Develop and implement a contemporary overall strategic plan.
- Secure cash resources to avoid permanent and irreversible consequences to core service levels and mission due to current cash crisis.
- Develop and implement a primary care and outpatient services strategy.
- Reduce length of stay to clinical optimal levels.

- Provide budgeting and other financial reporting with integrity and credibility.
- Maximize the leverage of the Jackson Health Plan.
- Shift the labor cost curve through universal adoption of evidence based medicine guidelines; treating each patient in the most cost effective, clinically appropriate setting; improving patient throughput and other measures.
- Optimize the relationship with the University of Miami.
- Position Jackson for success in an ACO and/or capitated environment.
- Enhance information technology solutions to achieve meaningful use standards.
- Position Jackson to participate successfully in the HHS Patient Safety Initiative Funding Program.

These are several of the mission critical objectives for Jackson to immediately pursue within the revised executive leadership team and newly enacted financial recovery board.

There are certain attributes of any governance model that the task force believes are important for Jackson Health System. Miami-Dade County will always be a vital component of the governance structure of Jackson, even if a new model is ultimately selected, as it has the inherent responsibility to provide healthcare services to the underserved population of the County. Any newly created entity would undoubtedly seek financial support from the County, via the taxpayers, to support the valuable mission of Jackson. Therefore, the governance conversations need to remain open, transparent and in the sunshine to continue to preserve these interests.

The impact of a governance change on all sources of reimbursement, on the outstanding bond obligations, on the pension program, on sovereign immunity, and on other major components of the public healthcare model needs to be fully vetted to avoid any unintended consequences. It is irresponsible to provide specific recommendations on a governance model change, i.e. not-for-profit, without a full understanding of how a change in governance may impact these factors. The taskforce has not studied these issues with any level of specificity and is not in a position to make such recommendations.

As noted, any fundamental change in governance structure is a long term consideration as the financial recovery board should be allowed to address the immediate issues impacting Jackson. Continued exploration, including moving towards appropriate due diligence, should continue to be pursued to identify the optimal governance model for Jackson in the future.

Conclusions

- Jackson Health System is an important community resource and its mission is in jeopardy under the status quo.
- Greater accountability is required for the fulfillment of the mission within a sound financial framework, given budgetary restraints, reduced federal and state funding and competitive pressures.

- The evaluation of optimal governance models should continue in an effort to identify the most efficient and effective structure to allow Jackson Health System to fulfill its mission for decades to come. Any recommendations should be data driven and fully vetted to ensure that this very important assignment is handled with the highest degree of professionalism and responsibility.

- Legal and financial experts need to be engaged to perform the necessary due diligence. Any new structure should maintain Sovereign Immunity which goes hand in hand with the Sunshine Laws. The revenue streams should be enhanced, not decreased with any new structure. The eligibility for ad valorem and ½ cent sales tax should be fully studied to ensure continued availability to fund the mission of Jackson in any recommended model.

- The taskforce never considered or evaluated the risk to federal funding such as Intergovernmental Transfers (IGT) and Certified Public Expenditures (CPE) that a new structure such as not-for profit could possibly jeopardize. These federal monies are a real possibility and are being strategically pursued at JHS. A public structure is necessary to qualify as a recipient for these funds currently.

- The current effort has been very valuable but not sufficient to formulate any concrete solutions or recommendations.

- Task force membership should be re-evaluated to remove any task force members with a conflict of interest. Several members are direct competitors of Jackson and others have competing interests.

- A structure change to a private entity would most likely mandate a cessation in the Public Retirement System (FRS and PHT retirement) and the cost of doing so needs to be evaluated. The taskforce never explored or even recognized this risk which has the potential of significantly increasing the contribution from the employer.

- The Miami-Dade County Commission is an integral component of the governance of Jackson Health System and will continue to be so under any governance model. The tax payers of Miami Dade provide significant funding to Jackson and their elected officials are very relevant to its governance process.

- The immediate focus should be on developing a strategy for Jackson Health System to make it a more competitive alternative in the market place to serve everyone's healthcare needs in Miami-Dade County. The new executive team and the new financial recovery board should be given an opportunity to succeed with great assistance from the County.

- All current efforts regarding Jackson Health System should be directed towards averting a reduction in scope of services provided to County residents and to avoiding any deterioration to the great mission of Jackson. The operational issues denoted in this report should be the primary focus.

Submitted by:
Martha Baker, RN, President
SEIU Healthcare Florida, Local 1991

September 10, 2010

VIA HAND DELIVERY
& FACSIMILE

To: The Honorable Board of County Commissioners
Commissioner Dennis Moss, Chair
Commissioner Barbara Jordan
Commissioner Dorrin Rolle
Commissioner Audrey Edmonson
Commissioner Sally Heyman
Commissioner Bruno Barreiro
Commissioner Rebeca Sosa
Commissioner Carlos Gimenez
Commissioner Katy Sorenson
Commissioner Javier Souto
Commissioner Joe Martinez
Commissioner Jose "Pepe" Diaz
Commissioner Natacha Seijas

From: Martha Baker, RN, President, SEIU Local 1991

Re: Jackson Doctors, Nurses and Healthcare Professionals Respond to PHT Grand Jury Report (BCC Agenda Item 6B2)

Our healthcare union, which represents over 5,000 doctors, nurses and other healthcare professionals working at PHT/Jackson Health System, made the original request to have the Grand Jury investigate the operations of PHT/JHS. We did so because as we labor each day to save lives, we also are professionals dedicated to saving the public's health system.

We very much appreciate the efforts of the citizens who served on the Grand Jury. They recognized the importance of JHS to our community.

There are many important factual findings brought out by the report. These issues demand further investigation. However, there were multiple political conclusions and opinions offered by the report. If we are to have an honest discussion of the report it is critical that the community know the difference between political conclusions and factual findings.

Grand Jury Finds Evidence of Gross Operational Mismanagement Perpetrated by the PHT Administration and/or PHT Board.

The Grand Jury did an excellent job of framing the issues or as the report said, "incompentencies." Highlights of some of these findings include:

- Accounts receivables were overestimated by management and the PHT Board did not detect such errors, leading to a $50MM deficit instead of a $50MM gain in the 2009 budget.

- Management instituted a Net Patient Revenue Adjustment, and the PHT Board did not detect the error which lead to a falsely inflated revenue/AR. (pg 22)

- JHS management miscalculated contractual adjustments. As pointed out by the auditor, a huge error was created by JHS administration when it used an inaccurate reimbursement rate in calculating its projected revenue. (pg 23) The PHT Board never caught this error.

- Management thought there was a $46MM budget deficit in 2009. PHT Board thought the same. However, it took external auditors to disclose the real deficit of $244MM.

- The Revenue Cycle is broken and JHS was unable for years to properly collect on its billings. JHS paid millions to have Deloitte work at JHS with their primary assignment to fix the revenue cycle. Deloitte proceeded to rescue the broken department by staffing with their own employees and moving the entire billing world off campus. Then, when Deloitte left JHS 5 years later, the billing world collapsed again. JHS internal employees had never fully learned to properly collect all monies owed. JHS paid Deloitte greater than $80MM over five years.

- The words of the report sum up certain managerial incompetence. "We were stunned by the lack of competence certain witnesses demonstrated during the course of their testimony about the finances of JHS…It appears to us that persons at JHS are working in positions for which they are not qualified…We have no confidence in the numbers presented in the internal financial reports…." (pg 20-21).

- As the report stated, "management should have known there was a problem because JHS issues monthly financial statements to management and members of the PHT. For fiscal year 08-09 the monthly CFO reports reflected the following warning signs:

  - increase in money owed
  - decrease in cash on hand
  - decrease in cash and investments
  - decrease in money coming in

  The failure of the PHT [Board] to note this trend and address it in a timely manner may speak to the need to change the eligibility requirement for those serving on the PHT…"(Pg 26)

- "In the 2009 Audit Reports, the auditors found a certain deficiency that they considered a 'material weakness' in internal control, which affected the JHS financial statements." The auditors also reported "the checks and balances …were insufficient."(pg 29)

The Grand Jury Offered a Political Conclusion, not Based on the Facts in the Report, but Rather Based on Their Personal Desire to Blame the County Commission for the Crisis at Jackson.

One would hope that personal opinions would not be intertwined into a factual report. Unfortunately, regardless of the facts the Grand Jury found, its ultimate conclusion in every case was to blame the woes on the governing structure of the PHT. In the end the report essentially blames the County Commission for the managerial incompetencies of certain Jackson administrators and the lack of proper oversight by the PHT Board members themselves.

The Grand Jury makes a flawed recommendation to change the governance structure and actually give *more* autonomy to the very PHT Board that was unable (or perhaps unwilling) to catch management's mistakes and "incompetencies." The auditors talk about insufficient "checks and balances," yet the Grand Jury recommends removing a critical check and balance, the BCC.

Further, this report is being used by certain lobbyists to remove the ultimate check and balance, the voters of Dade County. They are disingenuously advocating to take away the right of the electorate to remove from office those who are accountable for Jackson by creating an insulated private organization.

There are many matters that may have lead to such gross incompetence at JHS. However, the Grand Jury only mainly focuses upon structure as the alleged culprit. With

millions of dollars mishandled not a single administrator was held accountable. No vendors or lobbyists were called into question. No indictments were issued. The report purposely avoided "naming names" – allowing public officials to evade responsibility.

The PHT Board only received one central admonishment. On pg 30 of the report it is written that, "The PHT's specific job is to make sure something like this does not happen." The PHT Board clearly failed to do their job. Yet the Grand Jury report suggests they get more autonomy in several arenas.

The County Commission and County Structure has Created an Outstanding Police Department, Nationally Recognized Fire Rescue Service, and World Class Healthcare at Jackson. Yet, now BCC is to be Blamed for the JHS Crisis.

How can the same BCC and County structure that manages our incredibly successful Police Department and Fire Rescue Department, become bumbling idiots with regard to PHT? The Police Department has the right to use lethal force. Fire Rescue becomes our front line during our most challenging crises. Why is it that only PHT business operation are running afoul of the public trust?

It is odd that the so called broken structure at PHT/JHS seems to also produce superb medical results. While some mangers and the PHT Board commit operational malpractice, the healthcare professionals at Jackson perform medical miracles every day. The employees should be commended for their continued deliverance of excellent healthcare when the systems around them are crumbling with incompetence. The employees not only gave 5 percent of their wages, but took voluntary demotions and froze wages and bonuses for 12 months adding up to a 7-12 percent contribution in reality. The employees at Jackson donated over 100 million in concessions this year alone. The union employees also have created an Efficiency Task Force that is saving JHS multiple millions.

To make Jackson Stronger We must have an Honest Community Dialogue and not Engage in Political Games. It is perverse that a Report that Allegedly Seeks to take the Politics out of Jackson, has done just the Opposite. Instead of Sticking to the Facts and Looking for Solutions, the Report Bootstraps a Preordained Conclusion and Blames Everthing on the Commission and the Employees. Simply put the Facts do not Support the Conclusion.

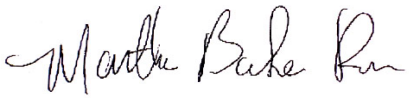
Critical stakeholders never appeared before the Grand Jury. Did any charity care patients testify? Did independent experts on hospital administration testify? Did renowned scholars on government and governance appear? Were any independent studies commissioned? We think not.

It is disconcerting also to note that many of the allegations and certain testimony presented was not verified or checked for accuracy. For example, the report is completely false when it reports that the BCC overruled the PHT and unilaterally gave employee raises. That never happened and the evidence proving otherwise is easily discoverable. We would like the Grand Jury to follow up to see if that witness committed perjury or was just mistaken.

It Is Time for the Stakeholders to come Together to Save Jackson

Instead of political gainsmenship, self-serving task forces and anointed committees of 41 throwing political rocks, it would be best for the community and the stakeholders to have an honest dialogue. Can one imagine what healthcare would be like if our doctors and nurses approached a heart attack patient in the same manner that the Grand Jury approached its political conclusion? We, as medical professionals, must every day labor to save our patients lives. We now call upon the BCC to approach the Jackson crisis with the same professionalism and honesty.

Sincerely,



Martha Baker, RN, President

CC: The Honorable Katherine Fernandez Rundle
The Honorable Mayor Carlos Alvarez
County Manager George Burgess
PHT President Dr. Eneida Roldan

Mr. Chairman and Task Force Members:

I am Otto Castillo, Vice President of the Government Supervisors Association of Florida and a Utilities Supply Supervisor in the County's Water & Sewer Department. Our union represents the Supervisory and Professional employees throughout County government – almost five thousand employees. We appreciate the opportunity to address the task force and hope that in your deliberations you remember that Miami-Dade County employs one of the largest work forces in South Florida which is made up of your fellow citizens who devote their life to public service by providing essential services to our community.

Let me call your attention to one provision of the Charter which has recently caused great concern for all unions that represent county employees. The use of the veto power by the Mayor to "trump" the action of the Commission in resolving collective bargaining impasse disputes in accordance with the provisions of Florida Statutes, Chapter 447 (the "Public Employees Relations Act"). That statute calls for the Commission (as in other Florida jurisdictions) to act as the final "court of appeal" when the negotiations between a union and the Mayor break down. When the Mayor uses his veto to negate the decision of the Commission, his act undermines the essence of the dispute resolution system established by the Florida Legislature.

Article 2, Section 2.02. E. already contains certain prohibitions on the use of the veto – we strongly suggest that labor contract disputes being resolved by the statutorily-prescribed method be added to that list of exceptions.

On behalf of our President, Greg Blackman, and our entire membership which spans every department in the County -- we thank you for your consideration.

THE VOICE OF LAW ENFORCEMENT

DADE COUNTY POLICE BENEVOLENT ASSOCIATION, INC.

May 14, 2012

Senator Rene Garcia, Chair
Miami-Dade Charter Review Task Force
1490 West 68 Street, Suite 201
Miami, FL 33014

RE: Miami-Dade Charter Review

Dear Chairman Garcia and Task Force Members:

On behalf of the Dade County Police Benevolent Association (PBA) and the men and women of law enforcement that we represent, let me begin by thanking you for accepting the challenge of reviewing Miami-Dade's Charter and coming up with solutions to better serve our community and those employees who devote themselves to public service. Our members live in this community, work in this community and all too often die protecting this community.

I understand that today is the last public hearing before the Charter Review Task Force. Unfortunately, we have been unable to attend any of the public hearings as we were not notified until late last week and we have been, and currently still are, out of town for the Law Enforcement Memorial, held in Washington D.C., honoring those men and women in law enforcement who paid the ultimate sacrifice while serving and protecting their community. Sadly, some of the officers' names being added to the Memorial are from right here in Miami-Dade County.

I regret not being able to appear before you on this important issue of reforming the Charter, but please accept this correspondence as our position and for your consideration. I urge you to create a public safety taxing district and an elected sheriff in order that government be able to fulfill its first responsibility of providing safety to its people without political interference. This community supports funding public safety and the ability to fund it appropriately should not be left to the whim of politics and politicians seeking to grandstand.

Notwithstanding any legal position and/or argument regarding the Mayor's ability to veto a labor contract dispute that is resolved by the statutorily prescribed method in State Statute, I would also urge you to consider adding labor contract disputes to the list of prohibitions on the use of the Mayoral veto contained in Article 2, Section 2.02.E. of the Charter, thereby further clarifying that it is the Commission, the legislative body, who makes the final decision when negotiations between a collective bargaining agent and the Mayor break down.

Thank you for your consideration

Sincerely,

for John Rivera
President

John Rivera, President • 10680 PBA Memorial Boulevard • (Northwest 25th Street) • Doral, Florida 33172-2108
Telephone: 305-593-0044 • Fax: 305-593-1901 • e-mail:pba@dcpba.org • website: www.dcpba.org

Other Business

Pantin, Les (Office of the Mayor)

From: webmaster@miamidade.gov
Sent: Tuesday, May 22, 2012 6:13 PM
To: Charter - Miami-Dade
Subject: Charter Review Suggestions

Contact Person: **Ty Shlackman**

E-mail: **ty@peoplestring.com**

Contact Phone Number:

Home Address: **12965 SW 112 AVE**

City: **Miami**

State: **Florida**

Zip Code: **33176**

Suggestions: **Incorporation 1. I oppose forcing all the remaining unincorporated areas of the county into becoming incorporated or being annexed. It is undemocratic and a violation of the residents right to self determination. No one has the right to force any community to incorporate or get annexed against their will. 2. IF all of the county becomes unincorporated, then the county government would become unnecessary and should then be abolished. 3. The requirement of 25% signatures of registered voters to start an incorporation process needs to be added to the county charter to ensure the county commission can't eliminate this important requirement. 4. The county charter should be amended to prevent county commissioners from sponsoring their own proposals for incorporation. This would prevent county commissioners from bypassing the 25% signature requirement that is required by the petition process for incorporation. 5. Any referendum on incorporation should be scheduled at the next general election not in a primary or special election. 6. A 60% majority vote should be required to approve the creation of a new municipality. 7. Require the Clerk Of The Circuit Court to certify the petition of ten percent of the qualified electors of the municipality and require the county commission to schedule a public referendum at the next scheduled general election and require a 60% majority vote of the qualified electors in regards to municipalities adopting, amending, or revoking a charter for its own government or abolishing its existence. Countywide Petition Process 1. The county charter should be amended to require that only 4% of the county's electors should be required to sign countywide petitions for charter amendment, initiative, and referendum. 2. The county charter should be amended to eliminate the requirement that each petition signature must be on a separate page. Salaries of County Commissioners and the County Mayor 1. County Commissioners should be given an annual salary of $40,000 which should be tied to not having any outside employment. 2. The County Mayor should be given an annual salary of $75,000 and should also be prohibited from having any outside employment. 3. The Mayor and County Commissioners should be prohibited from receiving a pension. Other items 1. The provision that allows the Board of County Commissioners to amend or repeal ordinances adopted by the electorate through initiatory proceedings one year after they've been adopted should be eliminated since this is undemocratic. 2. County Commissioners should be prohibited from receiving reimbursements for their expenses. 3. The $300 filing fee for candidates for County Commissioner and County Mayor should be eliminated. 4. The county should be prohibited from hiring paid lobbyists. 5. Comprehensive land use changes to the county's Comprehensive Master Development Plan should require final approval in a public referendum by the county's electors. 6. The county charter should be amended to include the public office of Community Councils for the residents of unincorporated areas, require that all Community Council members be elected by the residents of the unincorporated area they serve, and require that all Community Council members be registered voters in Miami-Dade County residing in the Community Council area they serve. 7. The county government should be prohibited from selling or giving away public assets without public approval from the electors of Miami-Dade County and prohibit the county from awarding no-bid contracts to private companies. 8. The County Commissioners authority to condemn property should be eliminated and the county's use of eminent domain should be restricted to only confiscating property that is being used for unlawful purposes or activities in violation of civil or criminal law or poses a threat to the health or safety of Miami-Dade County residents. 9. The Citizens Bill Of Rights should be amended to prohibit the county commission from**

borrowing money and a 60% majority vote in a referendum of the county's electors should be required to approve any tax or special assessment. 10. The county should be prohibited from using taxes and special assessments to subsidize privately owned for-profit corporations. 11. The Citizens Bill Of Rights should be amended to require public approval of the county budget by the county's electors. 12. The county charter should be amended to require that the budget report include the county's Comprehensive Annual Financial Report for the current fiscal year. 13. The county charter should be amended to prohibit all Miami-Dade County departments and agencies and all county agents and employees from receiving protection from civil lawsuits and criminal prosecution through sovereign immunity.

Pantin, Les (Office of the Mayor)

From: Robert Hyde <vosmus@yahoo.com>
Sent: Thursday, May 24, 2012 11:40 AM
To: Pantin, Les (Office of the Mayor)
Cc: n/a
Subject: Re: FW: MIAMI-DADE COUNTY CHARTER REVIEW TASK FORCE TO HOLD MEETING ON MAY 30
Attachments: image001.jpg

Hi.
I am so sad.
I work ciculation at 'The Miami Times 5:30AM Wednesdays.
I really was put out when the elected that day .
Robert Hyde

--- On **Thu, 5/24/12, Pantin, Les (Office of the Mayor) <*lpantin@miamidade.gov*>** wrote:

From: Pantin, Les (Office of the Mayor) <lpantin@miamidade.gov>
Subject: FW: MIAMI-DADE COUNTY CHARTER REVIEW TASK FORCE TO HOLD MEETING ON MAY 30
To:
Date: Thursday, May 24, 2012, 9:49 AM

FOR IMMEDIATE RELEASE:

MEDIA CONTACT:

Suzy Trutie

(305) 375-1545

strutie@miamidade.gov

MIAMI-DADE COUNTY CHARTER REVIEW TASK FORCE

It is the policy of Miami-Dade County to comply with all of the requirements of the Americans with Disabilities Act. The facility is accessible. For sign language interpreters, assistive listening devices or materials in accessible format, please call 305-375-1225 at least five days in advance.

MIAMI-DADE COUNTY

Stephen P. Clark Center

111 NW 1st Street, Miami, FL 33128

Pantin, Les (Office of the Mayor)

From: webmaster@miamidade.gov
Sent: Thursday, May 24, 2012 8:45 PM
To: Charter - Miami-Dade
Subject: Charter Review Suggestions

Contact Person: **William Brothers**

E-mail: **b.brothers@atlas.com**

Contact Phone Number: **3052981079**

Home Address: **14501 SW 94 Avenue**

City: **Miami**

State: **FL**

Zip Code: **33176**

Suggestions: **Please DO NOT incorporate. Thank you.**

Pantin, Les (Office of the Mayor)

From: webmaster@miamidade.gov
Sent: Thursday, May 24, 2012 8:41 PM
To: Charter - Miami-Dade
Subject: Charter Review Suggestions

Contact Person: **Nellie Brothers**

E-mail: **nelmom67@yahoo.com**

Contact Phone Number: **3052514879**

Home Address: **14501 SW 94 Avenue**

City: **Miami**

State: **FL**

Zip Code: **33176**

Suggestions: **I am against incorporation and I hope you will put it to vote. If it is forced in my area, please incorporate it into a large City. Thank you.**