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

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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)

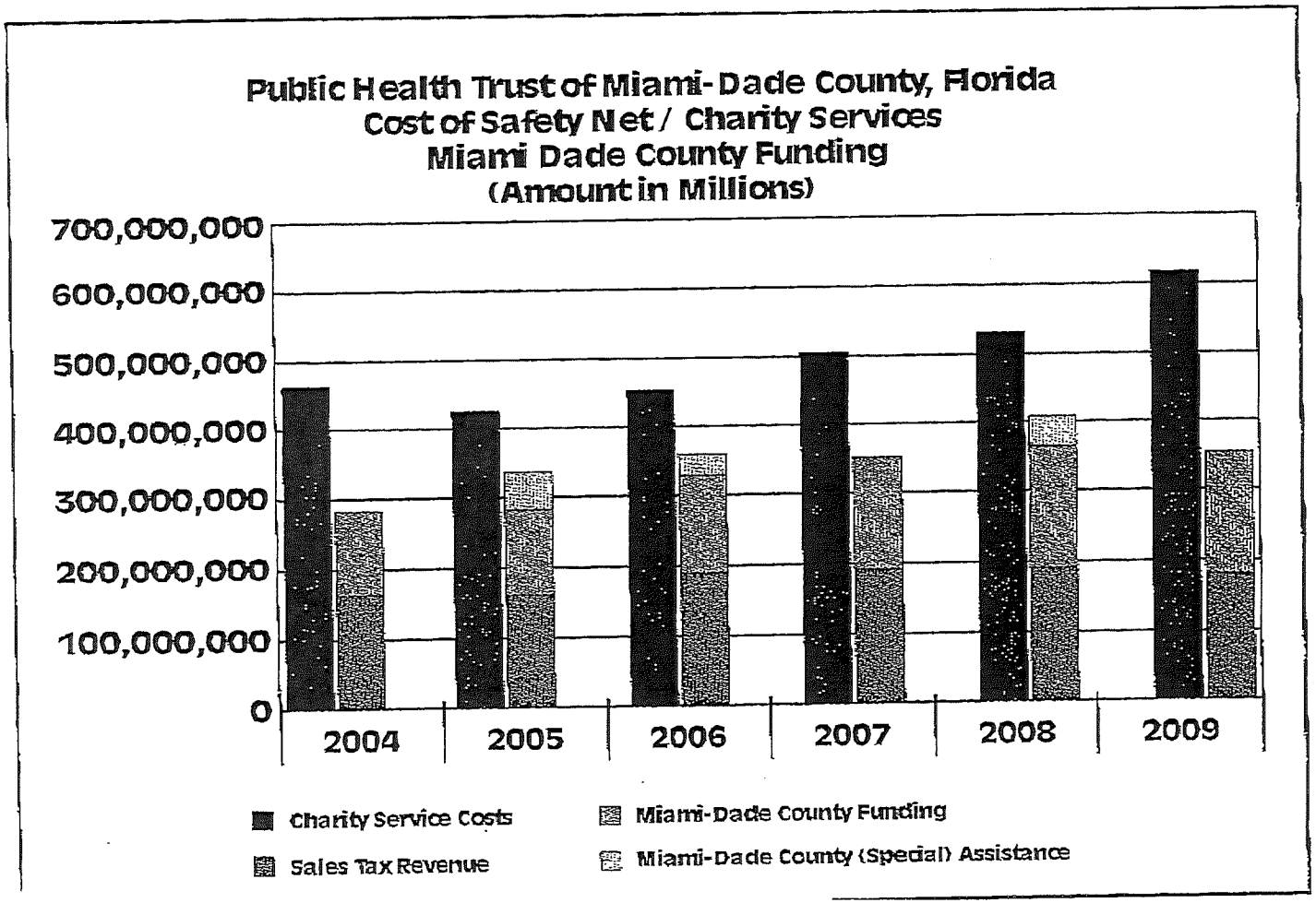

Exhibit 4

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