



Indian River Memorial Hospital, Inc. d/b/a

Indian River Medical Center

December 15, 2016; 10:00 a.m.

Boardroom

1000 36th Street

Vero Beach, FL 32960

This meeting may be recorded

Board of Directors

Board of Directors

For Information

I. Call to Order

Wayne T. Hockmeyer, Ph. D.

II. Consent Agenda

Wayne T. Hockmeyer, Ph. D.

a. Approval of Minutes

1. Minutes Dated November 2, 2016

Page 5

b. Joint Conference Committee

1. Confirmation of Medical Staff Elections

1. Department Chairs & Vice Chairs

Page 9

2. Medical Staff Representative to the Board of Directors

Page 10

2. Medical Staff Privilege Forms

1. Cardiovascular Surgery Privilege Set - TAVR

Page 11

c. Nominating Committee

1. Reappointments to the Class of 2019

Page 12

d. Governance Committee

1. Slate of Officers for 2017

Page 13

III. Foundation Chairman's Report

Jan Donlan

For Information

- a. Foundation Report November/December 2016

Page 14

IV. President's Report

Jeffrey L. Susi

For Information

- a. Appointment of Senior Vice President, Chief

For Action

Financial Officer - George Eighmy

Jeffrey L. Susi

- b. Appointment of Senior Vice President Chief Medical Officer - Katherine Grichnik, M.D.** *For Action*
Jeffrey L. Susi

- c. Appointment of President of Indian River Medical Associates - Charles Mackett, M.D.** *For Action*
Jeffrey L. Susi

- d. Appointment of Patient Safety Officer**

- e. President's Report - November/December 2016**

1. President's Report November/December 2016 **Page 17**

- f. Revised Organizational Chart**

1. Revised Organizational Chart **Page 22**

V. Finance Committee

Jack Weisbaum

- a. Financial Review**

1. FY 2017 YTD October Consolidated, Hospital and Physician **Page 23**

2. Financial Impact of Hurricane Matthew **Page 27**

- b. Pension Review**

1. Pension Plan Review **Page 30**

2. Willis Towers Watson - Pension Plan Review **Page 33**

- c. FY 201 Financial Performance Metrics**

1. FY 2016 Financial Performance Metrics **Page 56**

- d. Not-For-Profit Healthcare Outlook**

1. Moody's Investor Service - Medians _ Growing Revenue & Demand **Page 67**

2. Fitch Ratings - 2016 Median Ratios for Nonprofit Hospitals & Healthcare Organizations	Page 82
3. S&P Global Ratings - US Not For Profit Health Care Stand Alone Hospital Median Financial Ratios 2015 vs. 2014	Page 99

VI. Governance Committee

Gerri Smith

a. Governance Committee Charter

1. Approved in March of 2014	Page 107
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b. 2017 Proposed Meeting Schedule

1. January 2017 Meeting Schedule	Page 111
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c. Potential IRMC Board Transition Plan

1. Previously Discussed Board Transisiton Plan	Page 112
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2. Updated Draft Board Transistion Plan	Page 114
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d. Board Education

1. 2017 Proposed Education Schedule	Page 116
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VII. Other Business

Wayne T. Hockmeyer, Ph. D.

For Information

III. Public Comment

IX. Adjourn to the Private Session



**INDIAN RIVER MEMORIAL HOSPITAL, INC.
D/B/A
INDIAN RIVER MEDICAL CENTER
BOARD OF DIRECTORS
MINUTES**

The regular meeting of the Indian River Medical Center Board of Directors was convened by Chairman Wayne T. Hockmeyer, Ph.D. on November 2, 2016 at 10:00 in the Medical Center Boardroom.

MEMBERS PRESENT:

Wayne T. Hockmeyer, Ph.D.
William Baxt, M.D., via telephone
Hal Brown, M.D.
Michael Hammes, via telephone
Kathy Hendrix
Don Laurie
Juliette Lomax-Homer, M.D.
Keith Morgan
Hugh McCrystal, M.D.
Matthew Reiser
Gerri Smith
Jeffrey L. Susi
Jack Weisbaum

MEMBERS EXCUSED:

John Lindenthal, M.D.
Jack Pastor
Anthony Woodruff

OTHERS PRESENT:

Stephen Boruff
Liz Bruner
Lewis Clark
Jan Donlan
Jennifer Detmer
Gene Feinour
Warren Fuller
Greg Gardner
Katherine Grichnik, M.D.
Barbara Grimaldi
Lisa Hedenstrom, Ph.D., R.N
Kim Leach-Wright
Valerie Larcombe, Esq.
Lisa Licitra
Allen Jones
Charles Mackett, M.D.
Ann Marie McCrystal, R.N.
Robert Michael
Mindy Meyer-Corrado
William Neil
Camie Patterson
Grace Simonson
Richard Van Lith, Pharm. D.
Val Zudans, M.D.

CONSENT AGENDA

1. Approval of Minutes
 - a. Minutes dated August 25, 2016
2. Finance Committee
 - a. FY 2017 Operating and Capital Budget
 - b. Investment Committee
3. Investment Committee
 - a. Rebalance Pension Funds – Transfer \$3.5 Million from the Debt & Equity Category to the Cash Account to Reserve Funds for the Phase II Lump Sum Benefit Program

Dr. Hockmeyer asked the Board Members if anyone wished to remove any item under the Consent Agenda for further discussion. There were no requests.

Mr. Weisbaum commented on the FY 2016 unaudited year-end financials and the FY 2017 Operating and Capital Budget. He summarized the revenues and expenses explaining the variances from budget. He noted that the Hospital has been on a fast track to repay the debt associated with the purchase of VRA and the construction of the HWC. Repayment of the debt affects the Cash On Hand. The FY 2017 Operating and Capital Budget was presented to the Finance Committee in August and to the Board of Trustees in September.

Dr. Hockmeyer called for a Motion to Accept the Consent Agenda.

Upon **MOTION** made by Dr. McCrystal, duly seconded by Mr. Reiser and unanimously carried to approve the Consent Agenda as presented.

PRESIDENT'S REPORT

Over the past several years, there has been discussion about renovating the Nursing towers. The feedback on the recent additions along with renovations to SICU and 5N has been outstanding. Patients and families are enjoying the larger rooms with more amenities. The Hospital is almost 40 years old and is in need of modernization for appearance, function and infrastructure. During the renovations on 5N, some of the existing rooms were cannibalized to make larger rooms and increase efficiency. The Power Plant has issues as seen with the chiller pipe break last year. Mr. Susi explained that the following presentation is a concept for how, in the future, renovations of the facility could be achieved. This presentation does not include anything about funding. This is only a concept.

Mr. Susi presented Mindy Meyer-Corradò and Stephen Boruff from Stephen Boruff, AIA Architects & Planners. Ms. Meyer-Corradò explained the challenge to modernize the facility to enhance patient satisfaction. The existing private patient rooms are small, uninviting and the bathrooms are difficult to navigate. If each of the nursing wings were renovated the same as 5N, the bed count would be reduced from 286 to 192. Renovations are disruptive and costly and ultimately will not yield the bed count required to serve the community. Studying the renovation of the existing bed tower led to the conclusion that the institution cannot maintain capacity without first building new beds.

Ms. Meyer-Corradò presented several options with a goal to reach 226 modernized beds plus 40 Observation beds. The options were laid out in Phases over a period of six years. A new bed tower will create an inviting point of arrival and new main entrance. It will also allow for new beds while the old facility is renovated. The 1st Floor will include covered parking and a new entrance, physical therapy and

endoscopy entrance. The 2nd Floor includes renovated beds to Women's Health, expansion to the Surgical Suites and new beds to CCU and Observation for a total of 82 beds. The 3rd Floor of the New Tower will add 30 new beds. The 4th, 5th and 6th floors would be shelled out for 30 beds each. The 4 story option will allow for 228 beds with a 40 bed observation until. The 5 story option will give 216 beds and the 40 bed observation. Upgrading the Power Plant will achieve savings on utilities. The 3rd and 4th Floors of the existing building could have alternative uses.

Discussion ensued.

The Board agreed the 5 story or the 6 story options were best options with flexibility for alternative uses. The Board requested inflation costs in the next presentation.

Mr. Susi presented the following items from the President's Report which is attached and made part of the these Minutes

- The Florida Hospital Association (FHA) at its annual meeting in Orlando last week appointed Mr. Susi to the Board of Directors for a three-year term. It is a privilege to be part of this influential board. More than 200 Florida hospitals and health systems are part of this association, all working toward nurturing better healthcare and better value for consumers. The FHA leads hospital patient safety efforts through the Centers of Medicare & Medicaid Services Hospital Improvement Innovation Network (HIIN). Through 2019, participating hospitals will work to decrease patient harm by 20 percent and reduce hospital readmissions by 12 percent.
- Dr. Brett Faulknier has started to treat patients in IRMC's new cardiac electrophysiology (EP) lab. Dr. Faulknier is collaborating with James Daubert, MD, Professor of Medicine at the Duke University School of Medicine. He will be treating patients with heart arrhythmias or irregular heartbeats. The EP lab is the first in the state of Florida to add MediGuide™ Technology, a three-dimensional navigation system developed by St. Jude Medical, Inc., that provides recorded images of the heart muscle in action rather than a live series of X-ray images.
- On December 6th, the new Service Ambassadors will begin providing visitor badging at the Main entrance from 7:00 a.m. to 9:00 pm., Patient Pavilion entrance from 5:00 a.m. to 5:00 p.m., and the Emergency Department entrance 24/7.
- The 10th Anniversary of the Heart Program will be celebrated throughout the month of November. The first heart surgery was performed on November 6, 2006.

CHAIRMAN'S REPORT

Mr. Weisbaum shared with the Board a recent presentation that he gave to the Board of Trustees regarding Commercial Insurance. He reviewed a comparison of Hospital Efficiency and Commercial payments by hospital and by procedure. IRMC compares very favorably on a cost basis to other local institutions and the state average. Eighty percent of IRMC's payments come from Medicare, Medicaid and District funding. Only twenty percent comes from commercial insurance which, today, is probably at 145% of Medicare. There is room for increases. IRMC is sensitive to the other self-insured employers who might receive increases in their health insurance premiums.

Discussion ensued.

FOUNDATION REPORT

Ms. Donlan, President of the Foundation updated the Board on the Foundation's recent activities. She introduced Liz Bruner who was recently promoted to Vice President and Steve Harrison, a new member of the Team. The Campaign for Excellence is drawing to a conclusion and the donor board will be up at SWCC. The Foundation has updated the case statement for Cardiac Electrophysiology to expand the campaign to \$5 Million. There will be a series of events to celebrate the 10th Anniversary of the Heart Center. Marketing plans for the annual Planned Giving are being finalized.

FINANCE COMMITTEE

The Finance Committee reviewed the FY 2016 Year-To-Date Consolidated financials and the FY 2016 Goals and Objectives for the 4th Quarter. The Committee also received a report on Round 1 of the terminated vest lump sum project for the Frozen Pension Plan.

INVESTMENT COMMITTEE

The Investment Committee reviewed the third quarter investment results and discussed future trends.

PUBLIC COMMENT

Mr. Jones commented on the work that Dr. Katherine Grichnik is doing in her role as Chief Quality Officer. Developing a public scorecard will be critical to improving public opinion of IRMC. He encouraged more transparency.

Dr. Zudans addressed the Board with his opinion on the fiduciary duties of a board member, insurance rates, the financial health of IRMC and the clinical health of IRMC.

Dr. Hockmeyer thanked Mr. Jones and Dr. Zudans for the comments.

The meeting adjourned to the executive session at 11:54 a.m.

Respectfully submitted,

Gerri Smith
Secretary



MEDICAL STAFF LEADERSHIP – 2017 OFFICERS

Chief of Staff: **Hal Brown, M.D.**
Vice Chief of Staff: **John Lindenthal, M.D.**
Secretary/Treasurer: **Geoffrey Wolf, M.D.**

Medical Staff Representative to the Board of Directors:

Pranay Ramdev, M.D.

<u>DEPARTMENT</u>	<u>CHAIRPERSON</u>	<u>VICE CHAIRPERSON</u>
Anesthesiology	Geoffrey Wolf, M.D.	John Lindenthal, M.D.
Cardiology	Joshua Kieval, M.D.	Jay Midwall, M.D.
Emergency Medicine	Paul Giasi, MD	Brad Damiani, M.D.
Family Practice	Dennis Saver, M.D.	Arthur Splendoria, M.D.
Hospital Medicine	Richard Rothman, M.D.	Kristine County, D.O.
Imaging Sciences	Margaret Weeks, M.D.	Adam Armstead, M.D.
Medicine	Richard Handler, M.D.	Charles Callahan, M.D.
Obstetrics/Gynecology	George Fyffe, M.D.	James Presley, M.D.
Orthopedic Surgery	Richard Steinfeld, M.D.	Seth Coren, M.D.
Pathology	Kali Freeman, M.D.	Yunguang Liu, M.D.
Pediatrics	Marc McCain, M.D.	Marc McCain, M.D.
Psychiatry/Neurology	S. James Shafer, M.D.	Michele Ofner, M.D.
Surgery	Fabio Roberti, M.D.	Daniel Glotzer, M.D.

Medical Staff Representative to the Board of Directors:

Pranay Ramdev, M.D.

Effective January 2017 for a 2 Year Term

**INDIAN RIVER MEDICAL CENTER
1000 36th Street, Vero Beach, Florida 32960
Phone: (772) 567-4311, Extension 1239 Fax: (772) 563-4641**

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CLINICAL PRIVILEGES IN CARDIOVASCULAR SURGERY

Name: _____

Trans catheter Aortic Valve Replacement (TAVR)

*Initial Requirements for Provisional Privileges: Board certified in Interventional Cardiology or Cardiovascular Surgery or Thoracic Surgery. Interventional cardiologist or Cardiovascular Surgeons or Thoracic Surgeons with at least 100 career structural heart disease procedures; or 30 left-sided structural procedures in past year of which 60% should be balloon aortic valvuloplasty (BAV). Atrial septal defect and patent foramen ovale closure are not considered left-sided procedures. Current privileges in cardiovascular or thoracic surgery or interventional cardiology at IRMC.

FPPE: Documentation of device specific training as required by the manufacturer. Documentation of 2 proctored cases performed at IRMC. The physician participates in a prospective, nationally audited registry. Registry will be used for assessment of quality with FPPE quarterly reports to physician and Department Chair. Full Privileges: The physician must submit case volume, outcome data, and registry reports for evaluation by the Section Chief (if applicable), Department Chair, Credentials Committee, and MEC. Procedure review will be performed as part of initial FPPE for all physicians during the first 6 months. It is the responsibility of the applicant to verify that this information and a request for full privileges is submitted.

OPPE: The physician participates in a prospective, nationally audited registry. Registry will be used for assessment of quality with OPPE reports to physician and Department Chair every six months.

*Reappointment Requirements: Physician maintains experience of at least 6 cases every 2 years.

Reappointments to the Class of 2019

- Wayne Hockmeyer, Ph.D., Chairman
- Jack Pastor, Vice Chairman
- Hugh McCrystal, M.D.

Reappointment to Class of 2019 by the Board of Trustees

- Matthew Reiser

Proposed 2017 Slate of Officers

Wayne T. Hockmeyer, Ph.D.
Chairman

Jack Pastor
Vice Chairman

Gerri Smith
Secretary

Jack Weisbaum
Treasurer

Jeffrey L. Susi
President/CEO

Foundation

Indian River Medical Center Foundation Report
Indian River Medical Center
Board of Directors
October/November 2016

Campaign for Excellence in Cancer Care

With a year-end campaign appeal sent to donors and prospects, gifts are expected through the end of the calendar year as supporters maximize their charitable giving tax deductions and seize the final opportunity to be on the Scully-Welsh Cancer Center donor wall. In a new approach, these appeals were personalized by community for John's Island, Grand Harbor and The Moorings, with letters sent under the signatures of the Leadership Committees in each of those communities. Targeted recipients elsewhere on the barrier island and mainland received their appeals from the Foundation Executive Committee.

A powerful letter of gratitude and Scully-Welsh Cancer Center updates penned by Dr. Jim Grichnik was also distributed to members of The Eagle Society. The accomplishments highlighted in this communique are sure to enhance year-end solicitations as the current campaign draws to a close. The Foundation expects to surpass its \$48-million goal, though support for the comprehensive cancer program will remain an option for donors into the future. Plans are to install the permanent donor recognition display in the Scully-Welsh Cancer Center after the first of the year.

10th Anniversary of The Heart Center at IRMC

The Foundation hosted two extremely successful events to launch the year-long 10th anniversary celebration. On November 9, more than 150 physicians, nurses, and clinicians attended a reception in their honor at the new Health and Wellness Center. All were thrilled to learn of the renaming of the program to Welsh Heart Center, in honor of the generosity of Carol and Pat Welsh, and to hear from these philanthropic donors that their motivation is to enable the team to save and improve more lives. After the surprise naming announcement, 17 original heart team members, christened "Founders" by Dr. Cary Stowe, were individually recognized for their service. Each received a lab jacket bearing the new

Welsh logo. During the cocktail reception, all other heart team members also received their new lab jacket or scrub top.

The following evening, at a private event hosted by Linda and Neill Currie, Foundation Board Member, the naming of the Welsh Heart Center was revealed to a group of nearly 100 donors, Duke Health representatives, and IRMC heart team members. On top of the naming news, two very special announcements were shared, thanks to the thoughtful gift planning of the late Champ Sheridan, whose estate included a \$2.5 million gift to the Foundation. With Champ's children Barrett and Chip present, the Dr. Cary L. Stowe Endowed Chair for Cardiovascular Surgery was initiated with \$1.25 million from the Sheridan gift. The pure surprise on Dr.'s Stowe's face and the cheer of support from his colleagues ensured this would be an unforgettable evening. The remaining \$1.25 million was announced in support of the Cardiac Electrophysiology program, under the leadership of Dr. Brett Faulknier. Both initiatives have \$5 million goals with campaigns currently underway. Continuing advancements in life-saving cardiac care, such as the new Transaortic Valve Replacement (TAVR) program, also funded by the Welshes, are only possible through philanthropy.

Community Leadership Committees

Six of the seven Leadership Committees have initiated their seasonal activities, with Windsor to join the list upon their residents' return in January. Together, these volunteer leaders will host a robust schedule of events showcasing the Heart Center anniversary, in addition to illustrating successful physician recruitment enhanced by donor-funded technology and facilities.

In addition to events, committee members have begun touring the new Cardiac Electrophysiology Lab to learn firsthand about the unique assemblage of technology at IRMC. Tour-goers are awed by the leading-edge equipment which is truly state-of-the-art and unmatched in Florida and the Southeastern region. Equally impressive is the skill of Dr. Faulknier and the team, whose unbridled passion for their work receives as much feedback from guests as the Star Wars-like equipment.

Planned Giving

With the option for charitable IRA distributions now permanently available to qualified donors, the Foundation mailed a November promotional postcard to donors and potential donors age 70 ½ or older. The piece encourages meeting the required annual IRA distribution before year-end by making tax-free rollovers to IRMC.

The crowning result of last fiscal year's planned giving activities was receipt of a \$1 million Charitable Remainder Unitrust earmarked for Excellence in Cancer Care. Additionally, Charitable Gift Annuities are seeing a resurgence in popularity among donors 80+ who want to make a legacy gift while also receiving a charitable tax deduction and annuity payments for the remainder of their lives.

FY17 What Really Matters - Unrestricted

By the second week of October, 2016 approximately 11,600 households had received a direct mail appeal for gifts in support of What Really Matters, unrestricted giving in support of IRMC's greatest needs to advance technologies, enhance facilities and elevate patient care at IRMC. As of November 30, 2016, the Foundation had received \$540,278 in unrestricted gifts and pledges for the Unrestricted Fund in FY17 vs. \$342,077 in unrestricted gifts and pledges for the same period last year representing an increase of \$198,201 or 57.94%. In addition to direct mail appeals unrestricted contributions are also generated by special mailings, honor/memorials, personal solicitations, and estate distributions. A direct mail appeal is scheduled the first week of December as an end-of-calendar-year gift reminder to those who have not responded to the October appeal and others that provides three funding opportunities from which donors may choose: IRMC's Electrophysiology Program, Excellence in Cancer Care and unrestricted. An important component of the December appeal is the opportunity to make a minimum gift of \$10,000 to Excellence in Cancer Care by December 31 in order to be included on the permanent Campaign for Excellence in Cancer Care donor wall located in the lobby of the Scully-Welsh Cancer Center.

May Pops

Mark your calendars for the 28th annual May Pops: Sunday, May 7, 2017 at Windsor. Sponsorship opportunities are available by calling 772.226.4955.

PRESIDENT'S REPORT

November/December 2016

- Virginia Mason Update

Following Dr. Gary Kaplan's presentation to the Board and Executive Management Team, we have had several follow up telephone conferences with Diane Miller, Executive Director of the Virginia Mason Institute, and Diana Moses, Director of Client Relations at Virginia Mason Institute. Additionally, Dr. Mackett, Dr. Grichnik and Val Larcombe, were able to attend the meeting of the Institute for Healthcare Improvement (IHI) in Orlando and have follow up discussion with Dr. Kaplan. I was able to attend a Virginia Mason Institute reception following the IHI meeting and meet several members of the Virginia Mason Board of Directors as well as management team.

Our next step will be a site visit to Virginia Mason. Our plan is to take a team that broadly represents IRMC including representation from the Board, Medical Staff (Private and Employed) Executive Management and General Management to attend the Virginia Mason orientation and the program "Leading With a Shared Vision", The visit is scheduled for January 31st thru February 3rd.

- Service Ambassadors – Visitor Badging Program

Beginning December 6th, all visitors to the Medical Center are now provided with identification badges upon entering the building. Service Ambassadors will implement the badging process using visitors' driver's licenses or other photo ID. This includes badging at:

- Visitor Entrance
- Patient Pavilion entrance
- Emergency Department entrance
- Outpatient Surgery Entrance – Registration will issue name tags

If someone does not have identification, they will be photographed by an ambassador. Ambassadors will verify someone has business in the hospital before they are allowed to enter the facility

IRMC employees are also being reminded "If you see something, say something." If something seems suspicious, call Security.

Meet our new Service Ambassadors!



- 10th Anniversary of The Heart Center at IRMC

The Foundation hosted two extremely successful events to launch the year-long 10th anniversary celebration. On November 9, more than 150 physicians, nurses, and clinicians attended a reception in their honor at the new Health and Wellness Center. All were thrilled to learn of the renaming of the program to the Welsh Heart Center, in honor of the generosity of Carol and Pat Welsh. Mr. Welsh shared with the group his motivation to support the program as a way to enable the team to save and improve more lives. He also expressed his view that the program has had a tremendous "return on investment" compared with other investments he has made, because of the great impact the program has had on patients and families. After the surprise naming of the Welsh Heart Center, 17 original heart team members, christened "Founders" by Dr. Cary Stowe, were individually recognized for their service. Each received a lab jacket bearing the new Welsh logo. During the cocktail reception, all other heart team members also received their new lab jacket or scrub top.

The following evening, at a private event hosted by Linda and Neill Currie, Foundation Board Member, the naming of the Welsh Heart Center was revealed to a group of nearly 100 donors, Duke Health representatives, and IRMC heart team members. On top of the naming news, two very special announcements were shared, thanks to the thoughtful gift planning of the late Champ Sheridan, whose estate included a \$2.5 million gift to the Foundation. With Champ's children Barrett and Chip present, the Dr. Cary L. Stowe Endowed Chair for Cardiovascular Surgery was initiated with \$1.25 million from the Sheridan gift. The pure surprise on Dr.'s Stowe's face and the cheer of support from his colleagues ensured this would be an unforgettable evening. The remaining \$1.25 million was announced in support of the Cardiac Electrophysiology program, under the leadership of Dr. Brett Faulkner. Both initiatives have \$5 million goals with campaigns currently underway. Continuing advancements in life-saving cardiac care, such as the new Transaortic Valve Replacement (TAVR) program, also funded by the Welshes, are only possible through philanthropy.

- Hospital Operations Update

- On December 1st, IRMC held the second LEADS (leadership exploration and development) Program. Attendees donated toys for holiday gifts to Safe Spaces. They also learned about AIDET (Acknowledge, Introduce, Duration, Explanation and Thank You) from EmCare, engagement survey results from Terry Hobbs and how to better manage our time, projects, meetings and ourselves from Pam Bietlich.



- A Patient Experience Team has been established with initial focus on HCAHPS and ED HCAHPS; using assessment report from HEI to drive improvements. This assessment validated much of the work that has already been done and the need to move performance to the ALWAYS level versus sometimes.

- Leaders have been trained on leader rounding for internal customers and have rolled out support service survey results. This will help ensure leaders & staff at the bedside are receiving great service from our internal service providers, such as EVS, HR, etc.
- Engagement Surveys from employees and physicians have been completed. The results were presented at the LEADS program. Results are being rolled out by Department Leaders to their respective Departments. It is essential for employees to know their feedback is important and it will be used to drive improvements. Teams/Staff are being asked to identify one question they want their unit/leader to focus on to improve next year's survey.
- Training for AIDET has been completed in the Emergency Department and at the LEADS program. Plans are being developed to cascade the training to all staff by leaders, along with validating that AIDET is being used consistently (always) and at a high quality.
- Senior Leader Rounding training has been completed with the Executive Management Team and the Department Leaders. Senior Leader Rounds directly address concerns raised in engagement survey about Senior Leader visibility needing to improve.
- Todd Bibens, Associate Vice President, has assumed additional responsibilities for the Emergency Department and is helping to drive improvements. Recruitment for a high performing Director is underway.
- Updating policies is an on-going project. Project Manager Kateland Hall has developed a plan to review all policies by April 2017. Recently purchased software will help assist the organization and improve future tracking of policy revisions.
- Lisa Hedenstrom's last day as CNO is December 9th. A recently established CNO Council meets weekly to update on projects and issues. The CNO Council includes Todd Bibens, Janet Longenberger, Sarah Mondano, Megan McFall, Karen Marple and Lori McCormack.
- Health & Wellness Center

All local employed Physician practices, excluding Partner's Physicians, moved into the Health and Wellness Center just before the Thanksgiving Holidays. The Physician offices are configured as follows:

 - 1st Floor- The Heart Center-Cardiologists, Cardiac Surgery, and Electrophysiology
 - 2nd Floor- Gastroenterology, General Surgery, Pulmonology, Internal Medicine and Medical Specialties
 - 3rd Floor- Urology, Orthopedic surgery, Rheumatology Neurosurgery, Neurology , and Concierge Medicine
- Daisy Award Winner

IRMC honored Peter LaPorta, RN, Intensive Care Unit, as its second DAISY Award winner. The DAISY Award celebrates nurses who demonstrate exceptional clinical skill and provide compassionate bedside care. The not-for-profit DAISY Foundation is based in Glen Ellen, CA, and was established by family members in memory of J. Patrick Barnes. Patrick died at the age of 33 in late 1999 from complications of Idiopathic Thrombocytopenic Purpura (ITP), a little known but not uncommon autoimmune disease. The care Patrick and his family received from nurses, while he was ill, inspired this unique means of thanking nurses for making a profound difference in the lives of their patients and patient families.



- Bed Tower

Following the presentation to the Board at the November 2nd meeting regarding the options for the Bed Tower and the “Modernization” of the IRMC patient rooms we have focused on fully defining cost, timing and sequencing to build a new 5 story or 6 story Bed Tower, followed by renovation and modernization of the existing bed towers and rooms. The results will be presented at the January Board meetings.

- First ‘Pinning’ Ceremony Held for New Employees

IRMC recently held its first “pinning” ceremony for new employees as they passed their first 90 days on the job. The new employees turned in their yellow star badge reel for a white badge reel with the IRMC logo and then capped off the event with a celebratory breakfast. In late 2015, IRMC launched a new program designed to ensure a welcoming environment for new employees. One key component of the program is the yellow star badge reel worn the first 90 days on the job. All employees are asked to participate by welcoming employees wearing the “new employee” badge.

- Special Procedures & Outpatient Endoscopy Team Up with the We-Care Program

Special Procedures and Outpatient Endoscopy staff teamed up with the Health Department We-Care Program for two We-Care clinics. The first clinic was on September 24, 2016 where 14 patients were seen for a total of 23 procedures. On December 4th, 11 patients were seen for a total of 16 procedures. Staff from both departments donated their time for either one or both Saturday clinics. Physicians volunteering their time were Drs. MacKay, Canipe, Grossman, Zerega, Lui and Joseph. Also volunteering time was Anesthesia of Indian River County. The anesthesiologists included Drs. Geoffrey Wolf, Franklin Cofresi and Linda Chabrier.

- Information Services Update

- Planning has started for next year’s major system upgrades and replacements:
 - Paragon 14.1 EHR/Financials – estimated start July 2017
 - McKesson Laboratory 16.0 System – estimated start February 2017
 - McKesson OneContent 17.5 (Legal Medical Record) – estimated start January 2017
- Employee Portal (Intranet) and Policy & Procedure System – estimated start January 2017
- The replacement of our current Human Resource / Payroll system is now in the build phase of the project. Pay rules, benefit categories, and all HR/Payroll policies and processes have been reviewed. We are currently targeting a go-live with the first payroll in April, 2017. The next and final phase of the project is scheduled for July 2017 with advanced employee scheduling and employee self-service.

- We have begun the technology install for our new Cardiology TAVR program. We are planning for a January 2017 completion for surgical cases to begin.
- The Health and Wellness Center IT infrastructure (networking, wireless access points, telephones and cellular availability) systems are in place. The physician office moves have been completed.
- Our IRMA EMR software, eClinical Works, is being upgraded to the newest release. Testing has begun with an estimated live date of February 2017.
- A pilot is underway for positive patient identification during the registration process using IRIS scanning as biometric technology. The goal is to reduce the registration process time for returning patients and to reduce the number of duplicate medical record numbers.

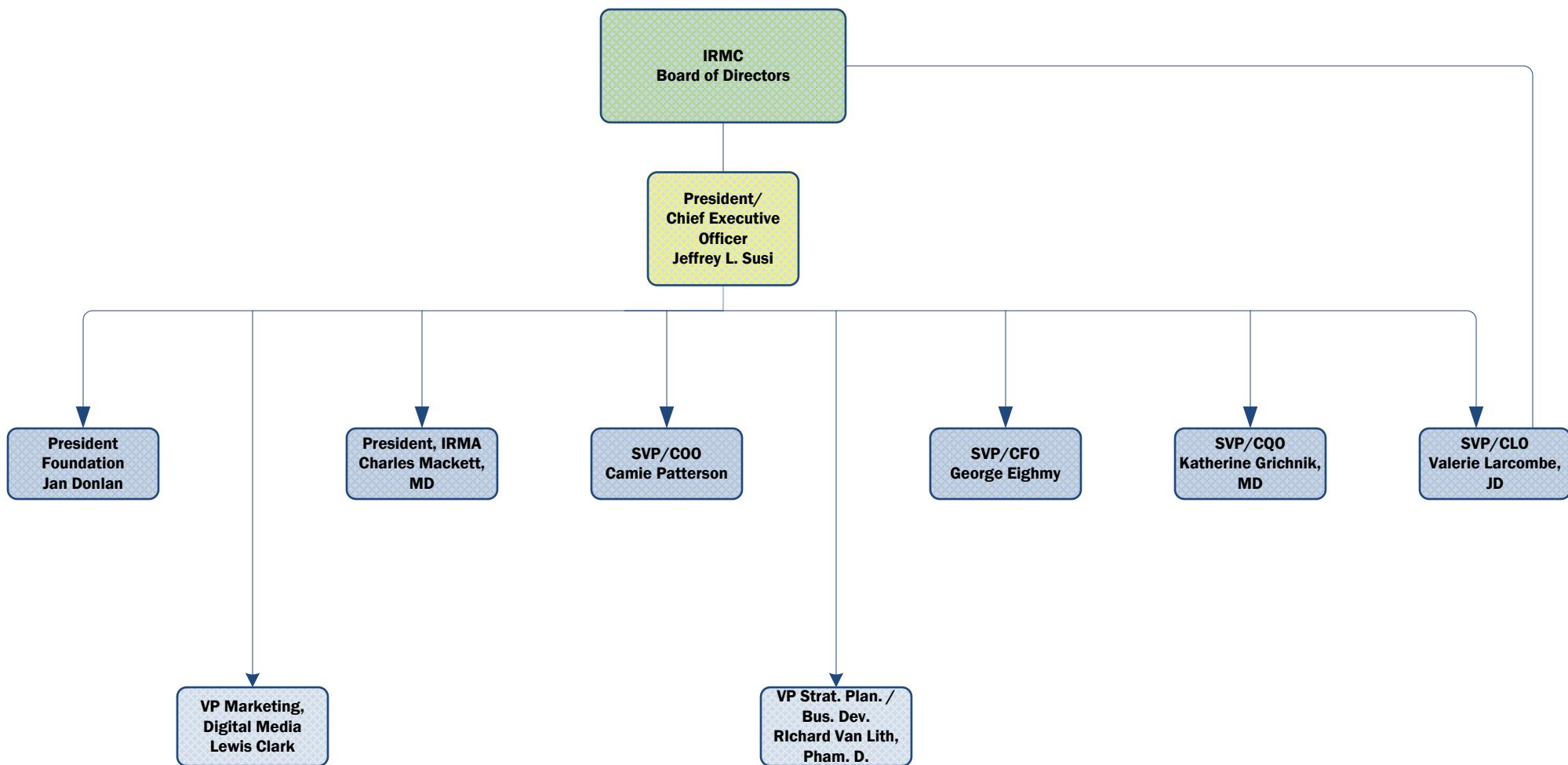
- Chaplain Office Update

The Chaplin's office asked the Marketing Department to create a process for allowing clergy members to access the "daily patient census" without having to travel to the Hospital. The daily patient census previously was only available by visiting the Chaplain's office.

Clergy members had voiced concerns over the difficulty of visiting the Hospital and sometimes missing members of their congregations. Marketing worked with Information Services (Bill Neil and Brian Look), Legal Services (Val Larcombe) and IRMC's Chaplain (Mindy Serafin) to understand the needs and opportunities available for the clergy.

Ensuring HIPAA compliance, the Legal team approved the creation of the "clergy portal". The Marketing team built a secured portal for clergy members to register an account and then access the daily patient census. The daily patient census contains the same information available from the paper copy – still available in the Chaplain's office. The advantages are clergy members can sort by name, religious type, location in the building or by specific unit. This portal allows clergy members to quickly access to their members within the Hospital.

Registered members can visit www.irmcClergy.com to login and search the daily patient census.

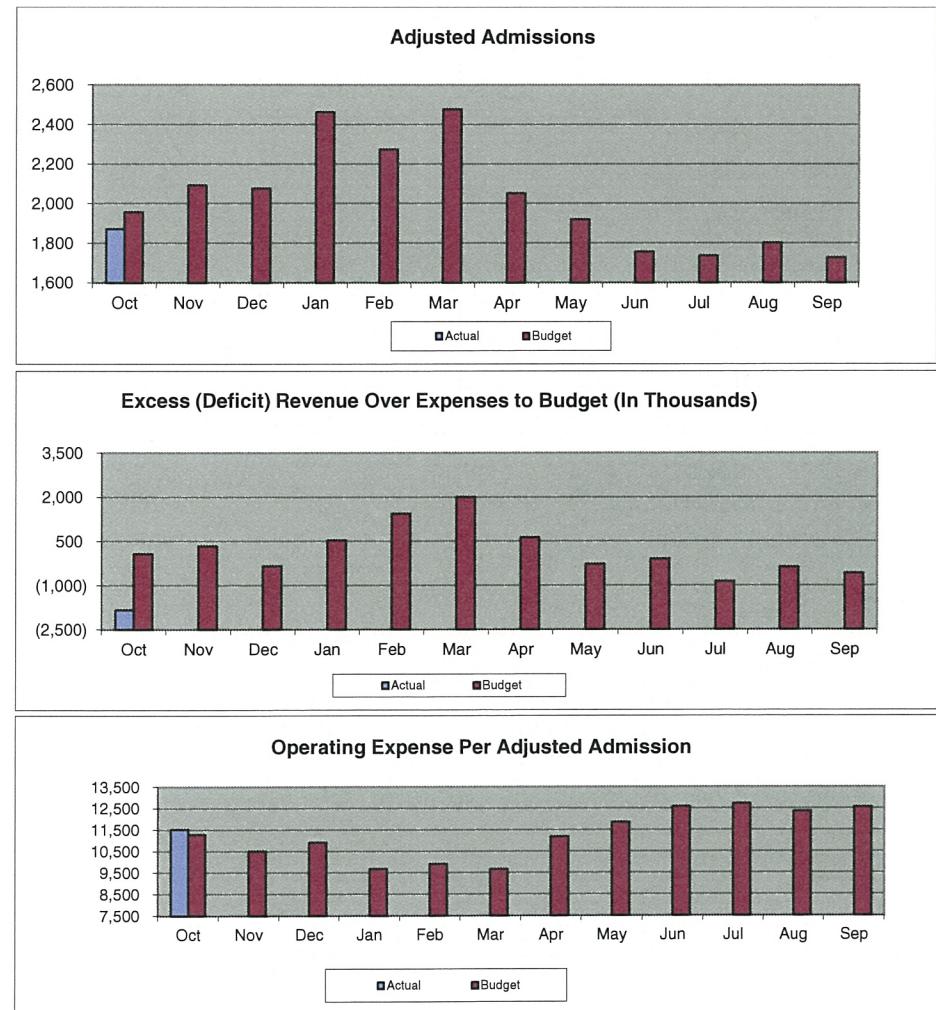


Direct Reports to President/CEO
December 9, 2016

Indian River Medical Center
Consolidated Financial Information
October 2016

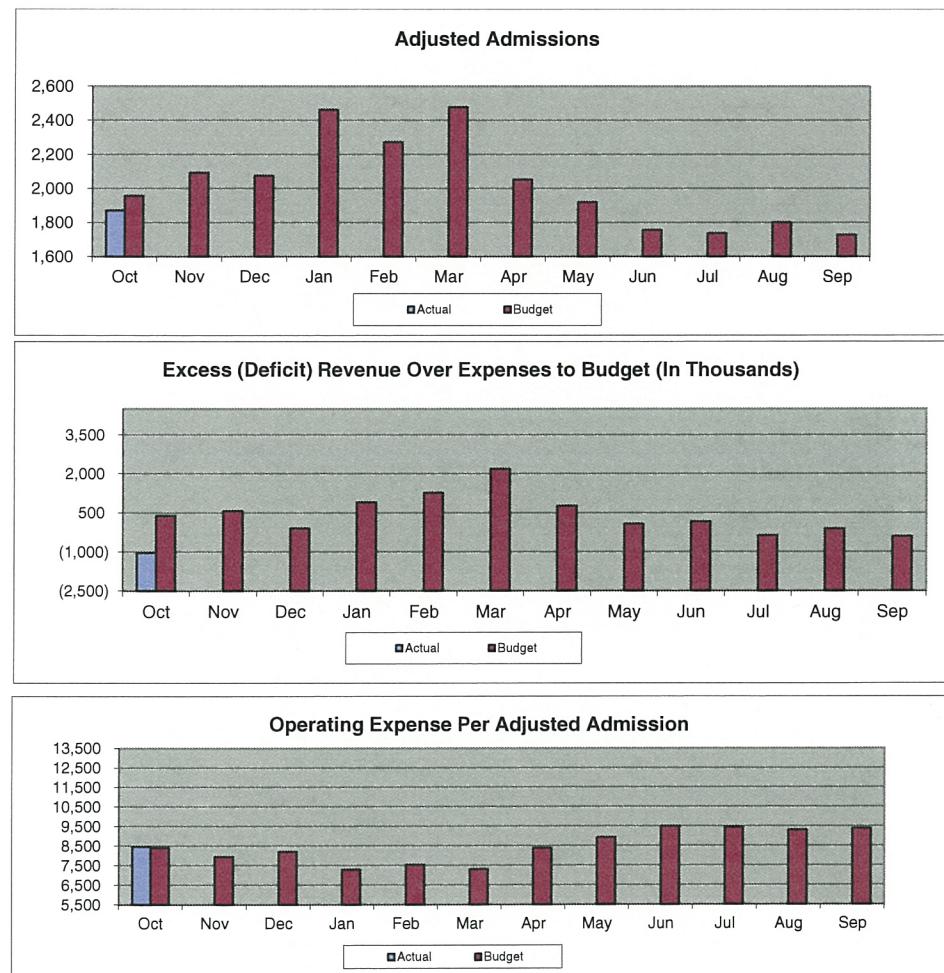
Volume	Month to Date			Act / Bud	Act / PY
	Actual	Budget	Prior Year	% Var	% Var
Admissions	1,044	1,165	1,238	-10.4%	-15.7%
Observation Discharges	460	505	341	-8.9%	34.9%
Total Admissions & Observation	1,504	1,670	1,579	-9.9%	-4.7%
Adjusted Admissions	1,871	1,957	2,141	-4.4%	-12.6%
Patient Days	4,437	4,873	4,867	-8.9%	-8.8%
Adjusted Patient Days	7,953	8,187	8,416	-2.9%	-5.5%
Average Daily Census	143	157	157	-8.9%	-8.8%
Urgent Care Visits	1,342	1,563	1,402	-14.1%	-4.3%
ER Visits	4,933	5,197	4,953	-5.1%	-0.4%
Surgeries	546	679	644	-19.6%	-15.2%
FTE's - Overall	1,631.1	1,597.1	1,515.5	2.1%	7.6%
AR Days	47.0	44.0	46.2	6.8%	1.7%
Days Cash on Hand	56.9	60.0	75.1	-5.2%	-24.3%
Case Mix Index	1.61	1.65	1.54	-2.3%	4.4%

Income Statement (in thousands)	Month to Date			Act / Bud	Act / PY
	Actual	Budget	Prior Year	% Var	% Var
Patient Revenue	18,736	21,343	17,493	-12.2%	7.1%
DSH / UPL	238	250	283	-4.8%	-16.0%
Medicaid / UPL	250	208	50	20.0%	400.0%
Other Revenue	1,220	1,194	1,328	2.2%	-8.2%
Bad Debt	(724)	(907)	(814)	-20.2%	-11.1%
Net Revenue	19,721	22,089	18,341	-10.7%	7.5%
Total Personnel Cost	12,468	12,020	10,796	3.7%	15.5%
Contracted and Other Services	4,471	4,758	3,941	-6.0%	13.5%
Supplies	3,439	4,186	3,624	-17.8%	-5.1%
Depreciation	1,150	1,143	1,065	0.6%	8.0%
Interest Expense	25	23	27		
Total Operating Exp	21,553	22,129	19,453	-2.6%	10.8%
Excess (Deficit) Revenue Over Expenses	(1,832)	(41)	(1,111)		



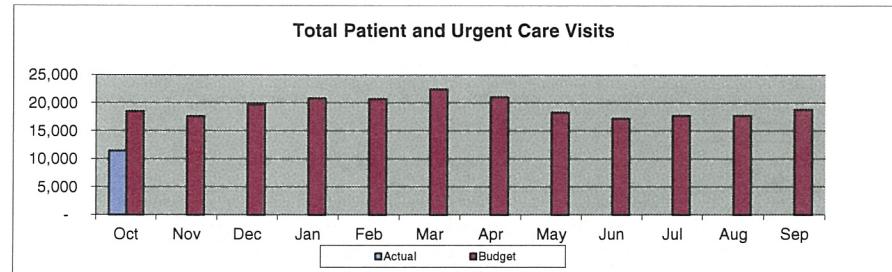
Indian River Medical Center
Hospital Only Financial Information
October 2016

Volume	Month to Date			Act / Bud	Act / PY
	Actual	Budget	Prior Year	% Var	% Var
Admissions	1,044	1,165	1,238	-10.4%	-15.7%
Observation Discharges	460	505	341	-8.9%	34.9%
Total Admissions & Observation	1,504	1,670	1,579	-9.9%	-4.7%
Adjusted Admissions	1,871	1,957	2,141	-4.4%	-12.6%
Patient Days	4,437	4,873	4,867	-8.9%	-8.8%
Adjusted Patient Days	7,953	8,187	8,416	-2.9%	-5.5%
Average Daily Census	143	157	157	-8.9%	-8.8%
ER Visits	4,933	5,197	4,953	-5.1%	-0.4%
Surgeries	546	679	644	-19.6%	-15.2%
FTE's - Overall	1,352.2	1,302.3	1,282.2	3.8%	5.5%
AR Days	44.3	41.0	43.4	8.0%	2.0%
Days Cash on Hand	56.9	60.0	75.1	-5.2%	-24.3%
Case Mix Index	1.61	1.65	1.54	-2.3%	4.4%
Income Statement (in thousands)	Month to Date			Act / Bud	Act / PY
	Actual	Budget	Prior Year	% Var	% Var
Patient Revenue	14,042	16,332	13,977	-14.0%	0.5%
DSH / UPL	238	250	283	-4.8%	-16.0%
Medicaid / UPL	250	208	50	20.0%	400.0%
Other Revenue	1,006	966	1,118	4.2%	-10.0%
Bad Debt	(724)	(907)	(814)	-20.2%	-11.1%
Net Revenue	14,813	16,849	14,615	-12.1%	1.4%
Total Personnel Cost	8,475	7,962	7,821	6.4%	8.4%
Contracted and Other Services	3,167	3,530	3,175	-10.3%	-0.3%
Supplies	3,199	3,963	3,419	-19.3%	-6.4%
Depreciation	1,005	1,006	943	-0.2%	6.6%
Interest Expense	-	-	-	-	-
Total Operating Exp	15,846	16,461	15,358	-3.7%	3.2%
Excess (Deficit) Revenue Over Expenses	(1,034)	388	(743)		

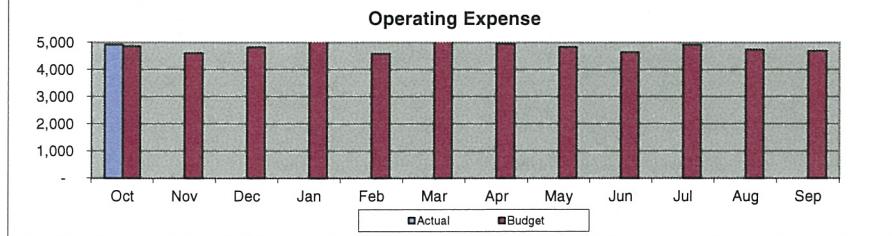
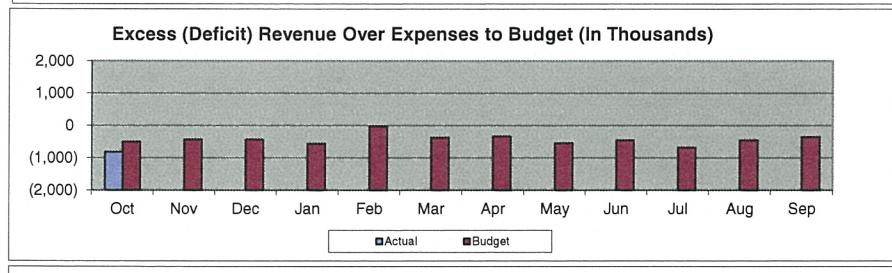


Indian River Medical Center
Physician Financial Information
October 2016

Volume	Month to Date			Act / Bud	Act / PY
	Actual	Budget	Prior Year	% Var	% Var
Patient Visits	10,117	16,895	12,058	-40.1%	-16.1%
Urgent Care Visits	1,342	1,563	1,402	-14.1%	-4.3%
FTE's - Overall	278.9	294.8	233.3	-5.4%	19.5%
AR Days	56.4	50.0	53.3	12.7%	5.7%



Income Statement (in thousands)	Month to Date			Act / Bud	Act / PY
	Actual	Budget	Prior Year	% Var	% Var
Patient Revenue	3,881	4,133	2,534	-6.1%	53.2%
DSH / UPL					
Medicaid / UPL					
Other Revenue	212	223	205	-5.0%	3.3%
Bad Debt	-	-	-		
Net Revenue	4,093	4,356	2,739	-6.0%	49.5%
Total Personnel Cost	3,694	3,749	2,660	-1.5%	38.9%
Contracted and Other Services	1,001	922	482	8.5%	107.6%
Supplies	156	126	91	24.1%	71.8%
Depreciation	60	62	62	-3.2%	-2.9%
Interest Expense	-	-	-		
Total Operating Exp	4,911	4,860	3,295	1.1%	49.0%
Excess (Deficit) Revenue Over Expenses	(818)	(503)	(556)		



Indian River Medical Center
Outpatient Imaging Services Financial Information
October 2016

Income Statement (in thousands)	Month to Date			Act / Bud % Var	Act / PY % Var
	Actual	Budget	Prior Year		
Patient Revenue	813	878	983	-7.4%	-17.3%
DSH / UPL	0	0	0		
Medicaid / UPL	0	0	0		
Other Revenue	2	5	5		
Bad Debt	-	-	-		
Net Revenue	815	883	988	-7.7%	-17.5%
Total Personnel Cost	299	309	315	-3.2%	-5.1%
Contracted and Other Services	304	305	284	-0.3%	7.0%
Supplies	83	97	114	-14.4%	-27.2%
Depreciation	85	74	60	14.9%	41.7%
Interest Expense	25	23	27	8.7%	-7.4%
Total Operating Exp	796	808	800	-1.5%	-0.5%
Excess (Deficit) Revenue Over Expenses	19	75	188	-74.6%	-89.9%

Indian River Medical Center

Estimated Impact from Hurricane Matthew

In thousands

	Hospital	Physician Services	Outpatient Imaging	Total
Estimated Loss Of Net revenue	\$ (656)	\$ (290)	\$ (121)	\$ (1,067)
Disaster Pay premium (October 6th 6 am- October 8th 7 pm) 13,841 hours	(222)			(222)
Disaster Additional resources (October 6th 6 am- October 8th 7 pm) 3,180 hours	(51)			(51)
Supply Costs savings- associated with loss of net revenue	79	12	12	103
Impact Excess Revenue over Expense	(850)	(278)	(109)	(1,237)
Excess Revenue over Expenses- Reported October 2016	(1,034)	(818)	20	(1,832)
Excess Revenue over Expenses- October 2016 Normalized	(184)	(540)	129	(595)
Excess Revenue over Expenses- October 2016 Budget	388	(503)	74	(41)
Excess Revenue over Expenses- Adjusted Variance	\$ (572)	\$ (37)	\$ 55	\$ (554)

Indian River Medical Center
October 2016 I/P Admissions versus Budget and Prior Year

Admission Type:	Actual	Budget	Actual		October	Actual	vs Prior Year	%
	October	October	vs Budget	Difference		2015	Difference	
2016	2016			%				
Medical:								
General	309	285	24	8%		352	(43)	-12%
Cardiology	75	95	(20)	-21%		119	(44)	-37%
Other	112	113	(1)	-1%		141	(29)	-21%
	496	493	3	1%		612	(116)	-19%
Surgical:								
Orthopedics	109	130	(21)	-16%		134	(25)	-19%
General Surgery	55	60	(5)	-8%		54	1	2%
Cardiovascular	27	34	(7)	-21%		17	10	59%
Other	95	122	(27)	-22%		111	(16)	-14%
	286	346	(60)	-17%		316	(30)	-9%
Deliveries:								
Mom	70	91	(21)	-23%		91	(21)	-23%
Nursery	70	91	(21)	-23%		91	(21)	-23%
	140	182	(42)	-23%		182	(42)	-23%
Behavioral Health:								
Adult	104	112	(8)	-7%		101	3	3%
Children	18	32	(14)	-44%		27	(9)	-33%
	122	144	(22)	-15%		128	(6)	-5%
Total Admissions	1,044	1,165	(121)	-10%		1,238	(194)	-16%
Estimated Impact of Hurricane Matthew	60	-	60			-	60	
Normalized Total Admissions	1,104	1,165	(61)	-5%		1,238	(134)	-11%
Observation Discharges	460	505	(45)	-9%		341	119	35%
Total Medical Admissions	496	493	3	1%		612	(116)	-19%
Total Medical I/P Admissions and O/P Observation	956	998	(42)	-4%		953	3	0%
O/P Surgeries:								
Orthopedics	33	30	3	10%		24	9	38%
General Surgery	86	125	(39)	-31%		122	(36)	-30%
Urology	52	55	(3)	-5%		53	(1)	-2%
Other	89	123	(34)	-28%		129	(40)	-31%
Total O/P Surgeries	260	333	(73)	-22%		328	(68)	-21%
Total I/P Surgeries	286	346	(60)	-17%		316	(30)	-9%
Total Surgeries	546	679	(133)	-20%		644	(98)	-15%
Estimated Impact of Hurricane Matthew:								
Loss of I/P Surgical Admissions	17		17					
Loss of O/P Surgeries	19		19					
Normalized Total Surgeries	582	679	(97)	-14%		644	(62)	-10%

October 2016 decline in I/P surgery is concentrated within Orthopedic, Neuro Surgery and O/B GYN

October 2016 decline in O/P surgery is concentrated within General, Vascular, Plastic and O/B GYN

Indian River Medical Center

Estimated Net Revenue Loss from Hurricane Matthew

	Wed. 10/5	Thur. 10/6	Fri. 10/7	Sat. 10/8	Cumulative 10/5-10/8	Net Revenue per Case or Admission	Net Revenue Loss
Documented Inpatient Admission Loss:							
Acute- Medical Admissions	18	10	18	27	73		
- Prior year	25	11	30	32	<u>98</u>	6,560	\$ (164,000)
Acute- Surgical Admissions	10	-	4	3	17		
- Prior year	8	15	11	-	<u>34</u>	14,600	(248,200)
Deliveries/ Newborns	-	-	4	4	8		
- Prior year	8	8	6	4	<u>26</u>	1,750	(31,500)
Estimated Loss of I/P Admissions and Net Revenue	(13)	(24)	(21)	(2)	(60)		(443,700)
 E/R Visits							
	157	89	138	192	576		
- Prior year	175	139	150	156	<u>620</u>	360	(15,840)
(44)							
 O/P Surgeries							
	9	-	-	1	10		
- Prior year	11	11	7	-	<u>29</u>	3,230	(61,370)
(19)							
 Outpatient Visits							
	159	19	11	50	239		
- Prior year	180	174	172	21	<u>547</u>	440	(135,520)
(308)							
Estimated Loss of O/P Net Revenue							(212,730)
Estimated Loss of Total Net Revenue						\$	(656,430)



Indian River
Medical Center

The Right Care Right Here

Pension Plan Review

December 13, 2016

Pension Plan Review



- Willis Towers Watson will provide the Finance Committee with a review of the pension plan and update assessment of pension plan risk transfer strategies. The table that follows shows the history of the balance of Pension Benefit Obligation and Plan Assets and the resulting funding statuses, over the 14 year period subsequent to the plan being frozen on December 31, 2002

Indian River Medical Center

Frozen Defined Benefit Contribution Pension Plan

Dollars in Millions

	Discount Rate	Expected			Benefits			Plan Assets	Funded Status	Funded Percentage	Additional Pension	
		Returns on Plan Assets	Pension Benefit Obligation	Contributions	Paid						(Liability)	
9/30/2002	7.25%	8.50%	\$ 52.8	\$ 1.4	\$ 1.8		\$ 28.5	\$ (24.3)	54.0%		\$	(2.1)
Plan Frozen on 12/31/2002												
9/30/2003	6.00%	8.50%	58.2	7.6	2.0		44.9	(13.3)	77.1%	0.9		(12.2)
9/30/2004	6.50%	8.25%	58.6	4.0	2.3		52.8	(5.8)	90.1%	1.2		4.2
9/30/2005	5.50%	8.25%	71.8	2.0	2.5		56.5	(11.4)	78.7%	1.2		(11.4)
9/30/2006	6.25%	8.25%	66.0	2.1	2.6		60.0	(6.0)	90.9%	1.3		6.7
9/30/2007	6.25%	8.25%	67.3	1.4	3.1		68.3	1.0	101.5%	1.6		6.8
9/30/2008	6.75%	8.25%	64.5	-	3.2		62.5	(2.0)	96.9%	1.6		(4.2)
9/30/2009	5.50%	8.25%	74.7	-	3.1		54.0	(20.7)	72.3%	1.7		(18.8)
9/30/2010	5.40%	8.25%	76.6	-	3.6		54.9	(21.7)	71.7%	1.7		1.2
9/30/2011	5.00%	8.25%	80.9	7.0	3.7		58.3	(22.6)	72.1%	2.2		(5.7)
9/30/2012	4.00%	8.00%	91.5	3.6	3.9		67.6	(23.9)	73.9%	2.0		(2.1)
9/30/2013	5.00%	7.75%	82.0	2.6	4.0		72.2	(9.8)	88.0%	2.2		11.2
9/30/2014	4.50%	7.50%	85.8	0.7	4.3		75.0	(10.8)	87.4%	(0.5)		(2.1)
9/30/2015	4.50%	7.25%	89.3	1.0	4.5		69.6	(19.7)	77.9%	(0.7)		(10.5)
9/30/2016	3.65%	7.25%	91.1	2.0	8.5		70.9	(20.2)	77.8%	0.3		(0.5)
Cumulative Change since plan was frozen	-3.60%	-1.25%	\$ 38.3	\$ 34.0	\$ 51.3		\$ 42.4	\$ 4.1	23.8%	\$	16.7	
9/30/2017- Projection	4.50%	7.00%	86.0	-	5.0		70.9	(15.1)	82.4%	(0.1)		5.1

Indian River Memorial Center

Pension Plan Review Finance Committee Meeting

December 13, 2016



Bob Bruechert
Lori Wolfersberger



Today's Agenda

- Overview
- Pension Accounting
- Funding Results
- Forecasts
- Appendix

Overview

- Economic Environment
 - Corporate bond rates declined roughly 80 basis points during fiscal year end 2016
 - Returns on Market Value of Assets for fiscal year 2016 were greater than expected
- GAAP Results
 - PBO funded ratio remained constant at 78%
 - \$2 million contribution in June 2016 and positive asset performance offset the discount rate drop
 - Expense for FY 2017 expected to be \$(103K), down from \$300K in FY 2016
- PPA Funding Results
 - Funded status remains over 100% as of 10/1/2015 due to ability to use artificially high legislated interest rates
 - Zero minimum required contribution for 10/1/2015 Plan Year
- Bulk Lump Sum Update
 - Approximately \$3.8M in lump sums paid in September 2016 to Terminated Vested former employees
 - \$5.2M in liability released (6% of total Plan PBO) for a \$1.4M gain
 - Reduced headcount by 178 vested terminated participants (12% of total Plan population)
 - Eliminated over \$300,000 in future PBGC and administration costs
 - Remained under the threshold for settlement accounting for FY 2016
 - Possible second offer in FYE 2017
 - May be offered to most of the Terminated Vested participants who were NOT included in 2016 and still remain under the settlement threshold

Overview

Capital Market Update as of September 30, 2016

- Bond rates have declined during 2016
 - Discount rate for expense is based on corporate bond rates as of the measurement date
- Willis Towers Watson Pension Index tracks the performance of a hypothetical pension plan
 - The benchmark plan discount rate decreased 79 basis points since 9/30/2015
- Benchmark portfolio return for a 60% / 40% allocation was higher than expected for FYE 2016

Pension Index Results			
Bond Yields	September 2016	September 2015	
- Benchmark Plan Discount Rate	3.57%	4.36%	-79 bp
- Citigroup HG Credit	3.48%	4.24%	-76 bp
- IRMC Discount rate	3.65%	4.50%	-85 bp
Benchmark Portfolio Returns	September 2016	Last 12 Months	
- 40% Stocks/ 60% Fixed Income	0.1%	8.4%	
- 60% Stocks/ 40% Fixed Income	0.2%	10.2%	

Willis Towers Watson Pension Index



Overview

Plan Asset Experience (\$000)

	2012	2013	2014	2015	2016
Values at 9/30					
- Fair Market Value ¹	\$ 67,630	\$72,240	\$75,037	\$69,566	\$70,890
- Return	16.49%	9.03%	9.12%	(2.70%)	11.52%
- Actuarial Value (Funding Only)	\$66,022	\$69,150	\$74,240	\$75,168	\$70,300*
- Return	8.60%	10.33%	11.82%	5.74%	6.23%*
¹ Market value shown does not include any contributions receivable.					

*Estimated - Final Actuarial value of assets (using 2-year smoothing) as of 10/1/2016 will be determined with the 10/1/2016 valuation – for purposes of pension funding

- The 11.52% return on market value of assets generated an asset gain of about \$2.9M relative to the 7.25% expected return
- The 5-year average return on Fair Market Value of assets through 9/30/2016 was 8.5%; the 5-year average return on Actuarial Value of assets was 8.5%.

Overview

Summary of Plan Participant Data

	10/1/2013	10/1/2014	10/1/2015
Participating Employees			
Frozen Active Participants	307	282	274
- Average Attained Age	54.3 years	54.8 years	55.6 years
Grandfathered Active Participants	1	n/a	n/a
- Average Attained Age	72.8 years	n/a	n/a
Terminated Vested Participants			
- Number	562	540	503
- Average Age	55.1 years	55.9 years	56.5 years
- Average Annual Benefits	\$3,772	\$3,749	\$3,557
Participants Receiving Benefits			
- Number	679	722	758
- Average Age	70.3 years	70.6 years	70.9 years
- Average Annual Benefits	\$6,214	\$6,127	\$6,077
- Total Annual Benefits	\$4,219,300	\$4,423,700	\$4,606,400
Total Participants	1,549	1,544	1,535

- The October 1, 2015 participant head count does not reflect the lump sum payments made in September 2016, which decreased the plan's headcount by 178.

Pension Accounting

Pension Accounting under GAAP

Year-End Accounting Balance Sheet Impact (\$000)

	FYE 2015 Actual	FYE 2016 Actual
Balance Sheet		
Projected Benefit Obligation (PBO)	\$ (89,270)	\$ (91,153)
Fair Value of Assets	<u>69,566</u>	<u>70,890</u>
Net Balance Sheet (Liability)/ Asset	\$ (19,704)	\$ (20,263)
Funded Status	77.9%	77.8%
Unrestricted Net Assets		
Net Prior Service Cost	\$ 0	\$ 0
Net (Gain)/Loss	<u>38,803</u>	<u>41,063</u>
Total Unrestricted Net Assets	\$ 38,803	\$ 41,063
- Change from Prior Year		\$ 2,260
Assumptions:		
- Discount Rate	4.50%	3.65%
- Expected Return on Assets	7.25%	7.25%
- Census Date	10/01/2014	10/01/2015
- Measurement Date (Assets and Liabilities)	09/30/2015	09/30/2016
- Mortality Table	RP 2014 (blue collar), with MP-2015 scale	RP 2014 (blue collar), with MP-2016 scale

- The PBO funded status decreased by \$1M primarily due to a the change in the discount rate offset by better than expected asset returns and \$2M in employer contributions during 2016

Pension Accounting under GAAP

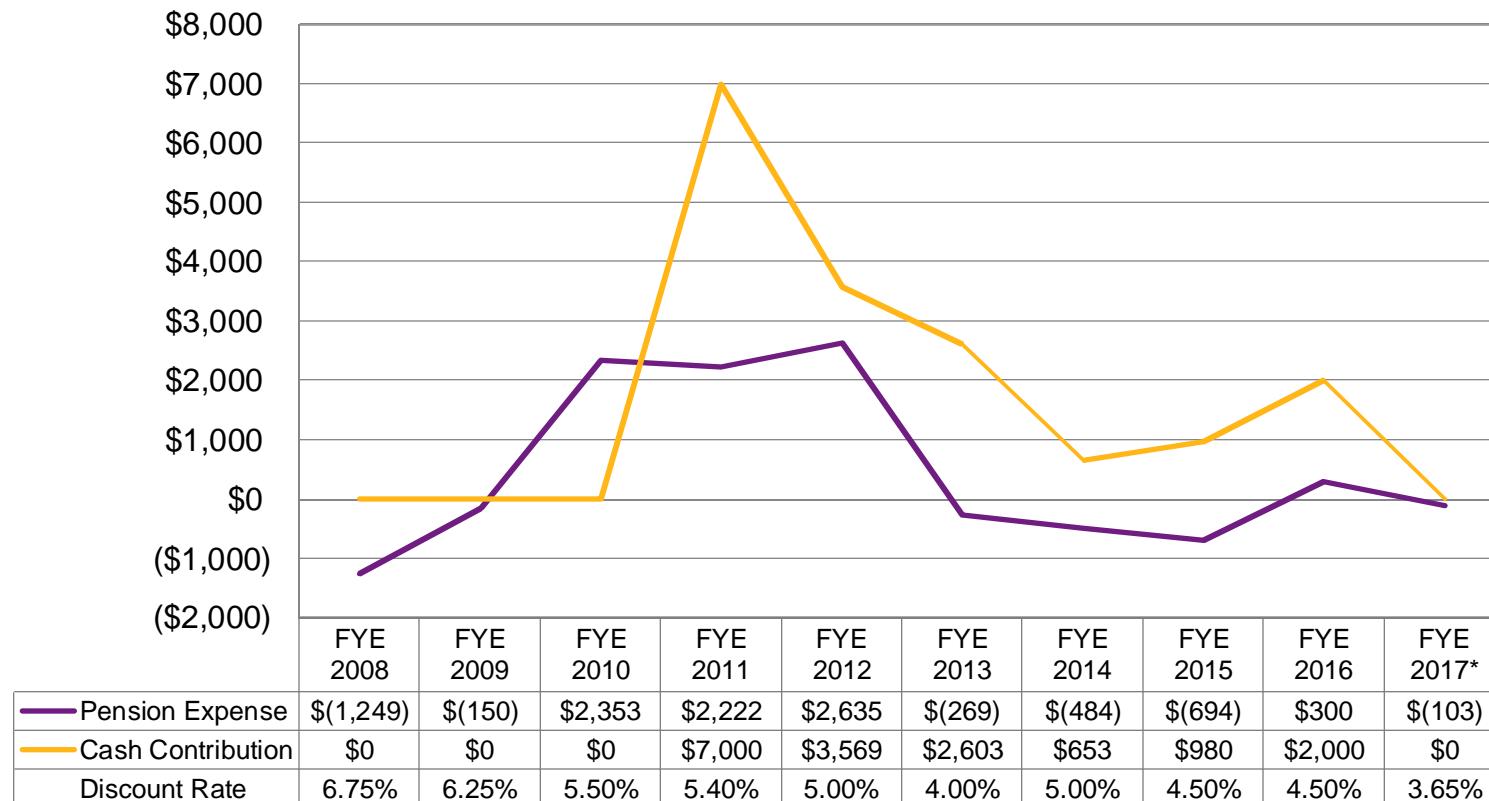
Annual Expense (\$000)

	FYE 2015 Actual	FYE 2016 Actual	FYE 2017 Preliminary
Expense			
Service Cost	\$ 0	\$ 0	\$ 0
Interest Cost	3,757	3,906	3,236
Expected Asset Return	(5,340)	(4,925)	(4,958)
Amortization of Net Prior Service Cost	-	-	-
Amortization of Net (Gain)/Loss	889	1,319	1,619
Total Expense	\$ (694)	\$ 300	\$ (103)
<u>Assumptions:</u>			
- Discount Rate	4.50%	4.50%	3.65%
- Expected Return on Assets	7.25%	7.25%	7.25%
- Census Date	10/01/2013	10/01/2014	10/01/2015
- Measurement Date (Assets and Liabilities)	09/30/2014	09/30/2015	09/30/2016
- Mortality	RP 2000, projected to 2020 with scale AA	RP 2014 (blue collar), with MP-2015 scale	RP 2014 (blue collar), with MP-2016 scale

- FYE 2017 expense decreased slightly due to the following:
 - Lower interest cost (due to a discount rate change)
 - Higher expected return on assets (due to higher fair value of assets)

Pension Accounting under GAAP

Plan History: Annual Expense & Employer Contributions by Fiscal Year (\$000)

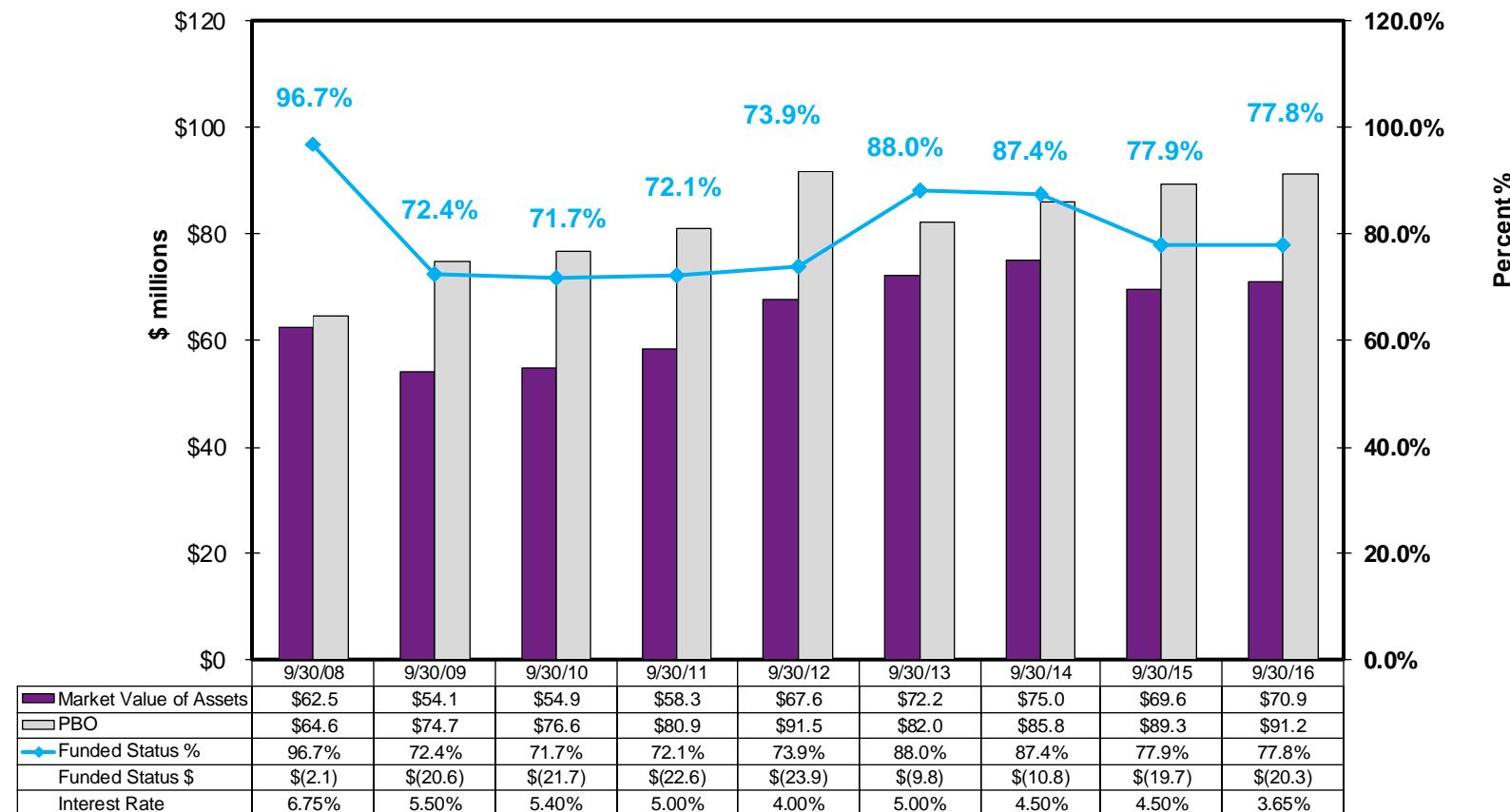


* FYE 17 cash contribution is to be determined; preliminary estimated minimum requirement is \$0.

- Pension Expense in FYE 2013 and later is based on the amortization of gains and losses over the average life expectancy of plan participants.

Pension Accounting under GAAP

Plan History: Funded Status



- The plan's funded status remained constant from the prior year

Funding Results

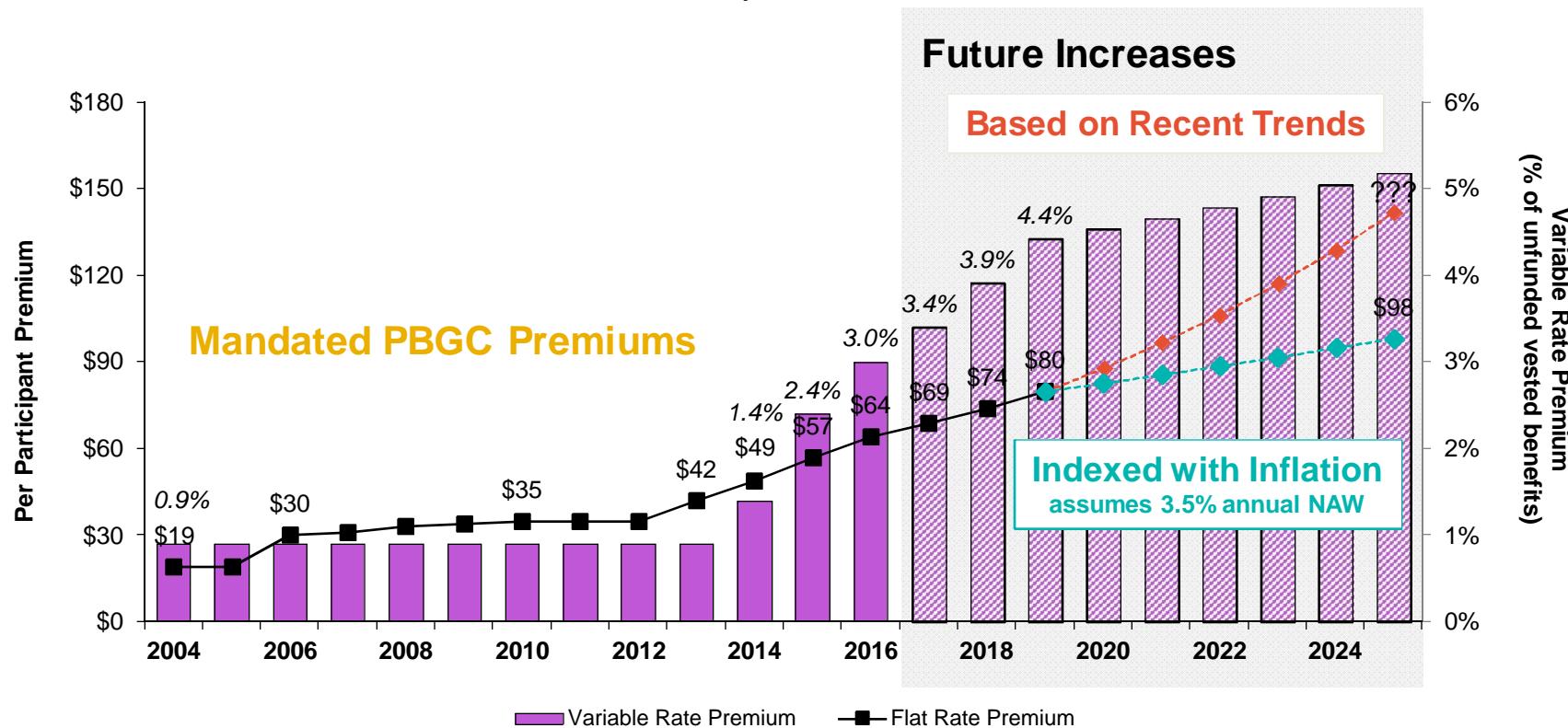
Funding Results

Plan Year Beginning 10/1	10/1/2014 Actual	10/1/2015 Actual
Pension Funding		
Target Liability	\$70,814	\$72,517
Fair Value of Assets	\$75,998	\$71,481
Actuarial Value of Assets	\$74,240	\$75,168
Underfunded Amount (based on Actuarial Value)	\$(3,194)	\$(2,422)
Adjusted Funding Target Attainment Percentage	104.5%	103.3%
Minimum Contribution	\$0	\$0
Effective Interest Rate	6.43%	6.21%

- Reflects post-HATFA effective interest rates
 - Rates must be within a corridor around the 25 year average rate - “artificially” inflated
- There is no minimum required contribution for the 2015 Plan Year
 - No quarterly contributions are required for the 10/1/2016 Plan Year

Ongoing PBGC Premium Increases

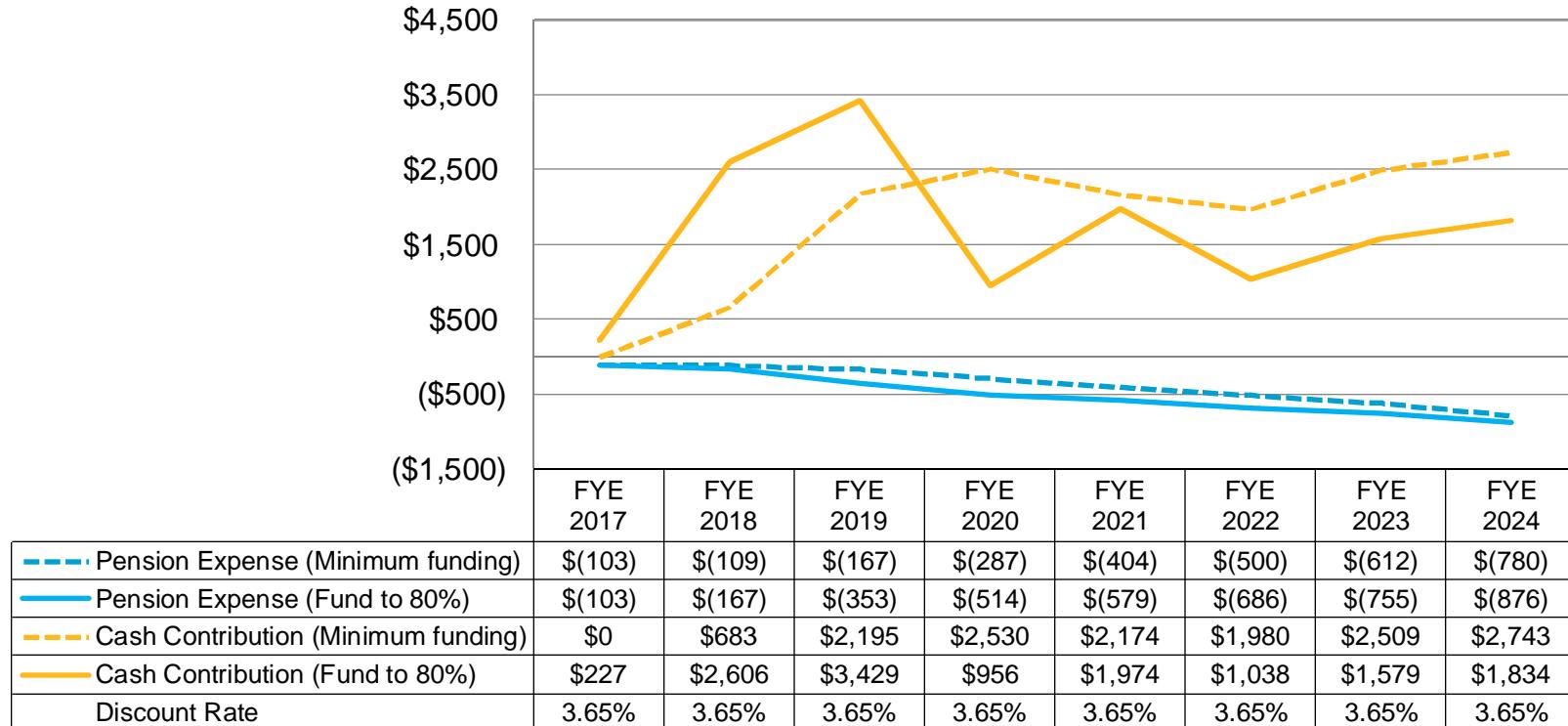
- Bipartisan Budget Act of 2015 increased PBGC flat and variable rate premiums for 2017 through 2019
 - This is the third time in three years the PBGC premium trajectory has been amended
- Relative to the 2012 levels, the 2019 premiums represent an increase of 129% for the flat rate and at least 356% for the variable premium



Forecasts

Forecasts

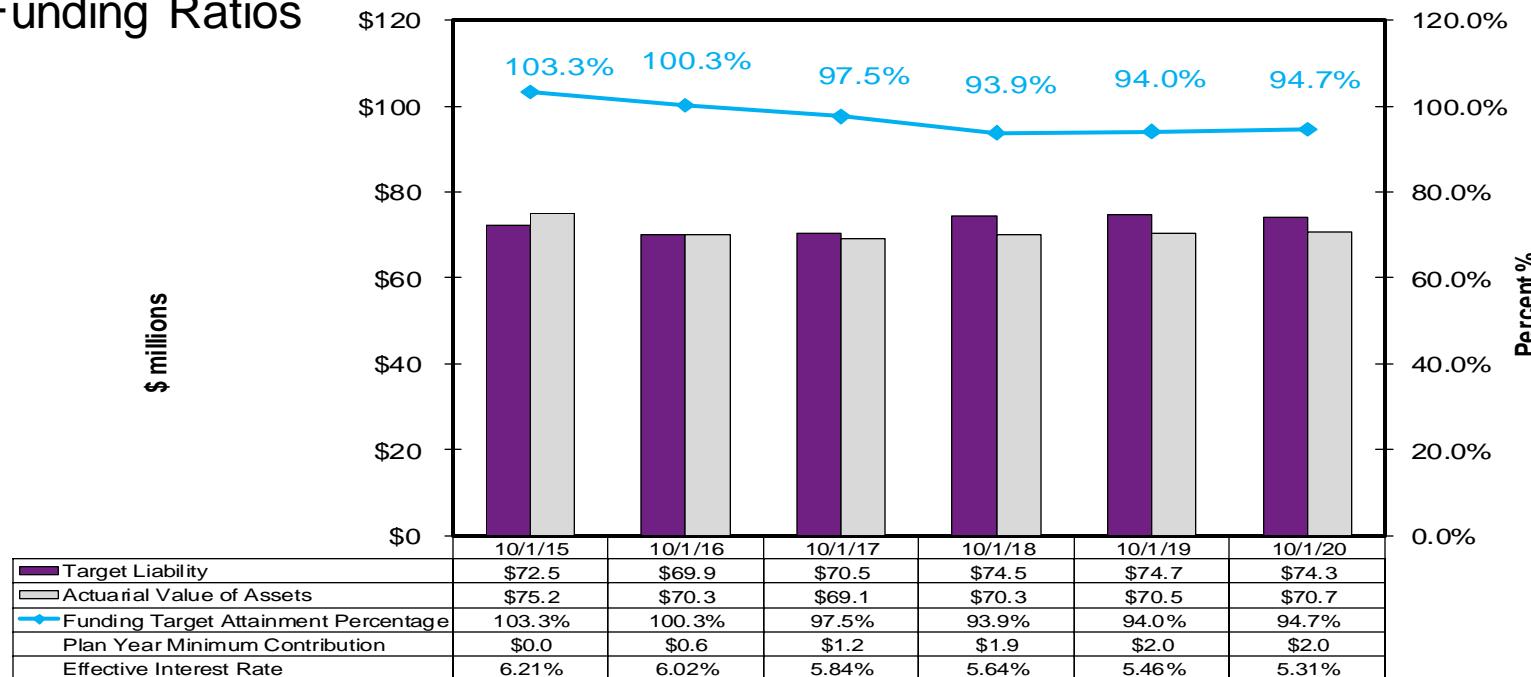
Annual Expense & Minimum Required Contributions (\$000 by fiscal year)



- The estimated 10/1/2016 results reflect data as of 10/1/2015, rolled forward and adjusted for the changes in assumptions; these results will change based on the actual 10/1/2016 valuation results
- Assumes an actual return on assets equal to the expected 7.25% for all fiscal years
- Reflects the RP-2014 blue collar mortality table with MP-2016 projection scale as of 9/30/2016

Forecasts

Funding Ratios



- The estimated 10/1/2016 results reflect data as of 10/1/2015, rolled forward and adjusted for the changes in assumptions; these results will change based on the actual 10/1/2016 valuation results
- Reflects post-MAP-21, post HATFA, and post Bipartisan Budget Act of 2015 effective interest rates, projected using current rates
- Assumes an actual return on assets equal to the expected 7.25% for all fiscal years
- Reflects a 5% increase in funding target to estimate the impact of the funding mortality table update as of 10/1/2018
 - Estimated using RP-2014 mortality table with MP-2016 projection scale as of 10/1/2018

Pension Plan De-Risking

De-Risking Marketplace

Regulatory Forces Continue to Impact Activity

PBGC Premiums

- 2013 Bipartisan Budget Act increased per-head premiums by 25% and variable premiums by 50%
- Additional increases in the 2015 Budget Act
- Premiums will continue to increase with inflation

Mortality Update

- Society of Actuaries released new base tables and improvement factors based on broad experience
- Increased average PBOs by approximately 5%, but not yet reflected in funding
- Estimated to increase cost of lump sums and funding target by 5% - 8% if/when adopted by IRS (2018 likely)

Regulatory Interest

- Increased interest from GAO, DOL, and IRS may lead to regulatory changes or negative publicity for de-risking actions

Considerations for 2017 Lump Sum Window

- As of September 30, 2016 there are approximately 140 Terminated Vested (TV) former employees in the Plan who were not offered a lump sum payout in 2016
 - During 2016, about 300 TVs with smaller benefits were offered a payout; during 2017 those with larger benefits will be offered a payout
 - The size and composition of the group will be refined to avoid a non-cash 'settlement charge'
- The estimated total Lump Sum value for these 140 TV participants is \$7.2M, compared to \$8.9M in liability on the 9/30/2016 Balance Sheet
 - Recent increase in interest rates provides an opportunity for savings
 - Potential gain of \$1.0 million (if 60% take-rate)
- The reduction in participant headcount is another 84 participants (assuming 60% acceptance), which would be another 6% of the plan population
- Would result in additional decreases in future PBGC and administration costs (about \$100K)

Appendix

Actuarial Assumptions

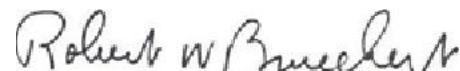
	10/1/2014 - 9/30/2015 Valuation	10/1/2015 - 9/30/2016 Valuation	10/1/2016 - 9/30/2017 Valuation
IRS Funding:	10/1/2014	10/1/2015	10/1/2016
- Effective Interest Rate	6.43%	6.21%	TBD
- Mortality	PPA Static	PPA Static	PPA Static
ASC 715-30 Expense:	FY 2015	FY 2016	FY 2017
- Discount Rate	4.50%	4.50%	3.65%
- Expected Asset Return	7.25%	7.25%	7.25%
- Mortality	RP 2000, projected to 2020 with scale AA	RP 2014 with blue collar adjustment, back to 2006, and generational projection using Scale MP-2015	RP 2014 with blue collar adjustment, back to 2006, and generational projection using Scale MP-2016
Both Funding & Expense:			
Assumed Retirement Age	55-65 graded	55-65 graded	55-65 graded
Employee Turnover	Rates by age	Rates by age	Rates by age

Actuarial Certification

In preparing the information detailed in this presentation, we have relied upon information regarding plan provisions and plan participants provided by IRMC and other persons or organizations designated by IRMC which is documented in our fiscal year 2016 Disclosure provided in November 2016. Therefore, such information including the reliances and limitations of the reports use should be considered part of this report.

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Lori Wolfersberger, F.S.A., E.A.
Consulting Actuary



Indian River
Medical Center

The Right Care Right Here

Financial Performance Metrics

Finance Committee
December 13, 2016

FINANCIAL PERFORMANCE METRICS



	S&P ALL	Median BBB	IRMC FY 2016	IRMC FY 2015
Number of Stand - Alone Hospitals Rated	476	97		
<u>Profitability Measures</u>				
Operating Margins	3.5%	2.4%	(.6)%	.6%
EBIDA Margin	12.2%	10.7%	5.7%	6.5%
Payor Mix				
<u>Liquidity Measures</u>				
Days Revenue in A/R	48.0	46.5	44.1	41.4
Days Cash on Hand	215	158	63	75
Days Cash on Hand, Net of Debt	52	1	5	34
Cushion Ratio	19	12.5	10.9	12.8
DB Pension Funded Status	75%	73%	78%	78%
<u>Capital Structure Ratios</u>				
Long-Term Debt to Capitalization	33%	36%	20%	14%
Debt Service Coverage	4.0	3.4	3.8	4.4

Source: S &P Research, 2015 median ratios for stand-alone hospitals, report dated September 21, 2016

OPERATING MARGIN



- Measures profit retained per dollar of revenue.
- Increasing values are favorable.
- This Profitability ratio (and others) at IRMC is weak.

In Millions:

<u>FY 2016 Operating Income</u>	<u>(1.6)</u>	=	-0.6%
FY 2016 Total Revenue	248.4		

- Used to value organization, regardless of capital structure.
- Often used as a measure of an organizations cash flow from operations.

In Millions:

Excess (deficit) of revenues over expenses plus interest expenses, depreciation and amortization

FY 2016= (1.2) + .8 + 14.3 = 13.9

EBIDA MARGIN



- Expression of EBIDA as percentage of total revenue.
- The gap between IRMC's EBIDA margin and investment grade bonds is much wider than gap in operating margin due to interest expense being low relative to industry standards.

In Millions:

<u>FY 2016 EBIDA</u>	<u>13.9</u>	=	5.7%
FY 2016 Total Revenue	248.4		

PAYOR MIX BY GROSS REVENUE



- Generally organizations with high Medicare and Medicaid utilization have lower profitability ratios.
- Organizations generate higher operating margins on Managed Care and Commercial insurance payor.
- IRMC's poor payor mix puts added pressure on its ability to generate positive profitability margins.

Median Payor Mix by Gross Revenue	S&P Median	IRMC FY 2015
Medicare	44%	66%
Medicaid	10%	10%
Managed Care/Commercial	39%	17%
Self Pay	7%	7%
	100%	100%

DAYS REVENUE IN ACCOUNTS RECEIVABLE



- Although A/R is grouped as a current asset, it can be viewed as a capital asset.
- The sooner A/R is converted to cash, the sooner the organization can do something productive with the money.

In Millions:

FY 2016

Net accounts receivable- 9/30/2016

patient revenue \div 365 days

$$\frac{28.1}{232.5 \div 365} = 44.1$$

DAY'S CASH ON HAND



- Measures the amount of cash available to meet operating expenses.

In Millions:

$$\text{FY 2016} \quad \frac{\text{Cash}}{\text{Total Expenses - Depreciation -} \\ \div 365} \quad \frac{40.3}{(250.0-14.3) \\ \div 365} = 63 \text{ Days}$$

CUSHION RATIO



- Measures the ability to cover debt obligations with current cash balance.
- IRMC's used its strong cash position in FY2010 to retire \$44M in principal outstanding.

In Millions:

$$\frac{\text{FY 2016} \quad \underline{\text{Cash}}}{\text{Annual Debt Service}} = \frac{40.3}{3.7} = 10.9$$

LONG-TERM DEBT TO CAPITALIZATION



- Indicator frequently used by lenders to assess an organizations debt capacity.
- Higher percentage values for this ratio imply a greater reliance on debt financing and reduced ability to carry additional debt.

In Millions:

FY 2016	Long-Term Debt	37.2	=	20%
	Unrestricted Net Assets + Long-Term Debt			

DEBT SERVICE COVERAGE



- Measures how many times the organizations debt service requirements could be met from existing cash flow.
- Higher values result in better bond ratings and lower cost of capital.

In Millions:

FY 2016

EBIDA	13.9	
Annual Debt Service	3.7	
	=	3.8



SECTOR IN-DEPTH

8 September 2016

Rate this Research »

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Not-for-Profit and Public Healthcare - US

Medians - Growing Revenue and Demand Support Strong Margins, Contraction Ahead

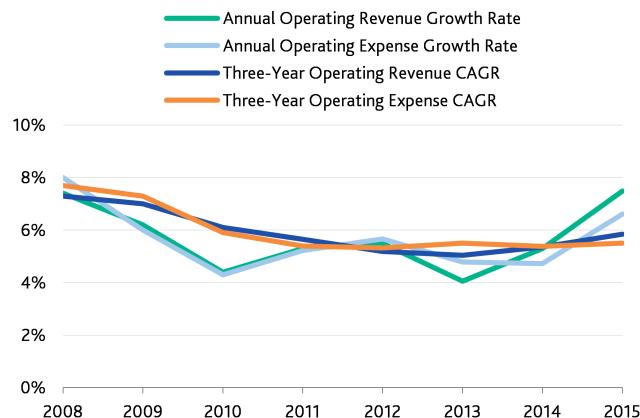
Not-for-profit and public healthcare revenue growth rebounded to levels not seen since fiscal year (FY) 2008 and exceeded expense growth for the second consecutive year, according to our FY 2015 medians. Steady revenue growth and strong financial margins support our [stable outlook for the sector](#).

The robust pace of improvements made in certain key trends will not likely be sustained given our expectations of moderating, albeit stable, fundamental business conditions across the sector. The slow shift to value-based reimbursement (where quality and outcomes play a greater role in hospital payments) from the predominant fee-for-service model (where hospitals are paid largely based on the volume of services provided) continues to be a long-term challenge for hospitals, placing downward pressure on financial performance and related metrics.

- » **Multi-year trend of strong annual and three-year revenue compounded annual growth rates (CAGR) underscores sector's stability for fiscal year 2016.** Annual revenue growth continued to outpace expense growth rate while three-year revenue CAGR eclipsed the three-year expense CAGR.
- » **Building on prior years' stable performance, the growth rates of absolute operating income and operating cashflow, as well as median profitability margins, surpassed historic levels.** Median 3.4% operating margin and 10.3% operating cash flow margin were at a multi-year high for the sector.
- » **Improvement in absolute liquidity was modest and days cash on hand flat despite upward trend in margins.** Positive operating trends and moderated capital spending balanced by weakened equity market returns contributed to tempered liquidity growth.
- » **All utilization measures showed improved growth rates as uninsured population declined for second year.** Demand trends reflected a more highly insured population and consolidation of the sector.
- » **Hospitals shied away from heavy investment in traditional bricks and mortar given challenges that face the sector while demand for information technology increased.** Though capital spending remained above depreciation levels, it has moderated since FY 2012 and the average age of plant has risen.

Exhibit 1

Revenue Growth Continued Favorable Trend, Outpaced Expense Growth Again



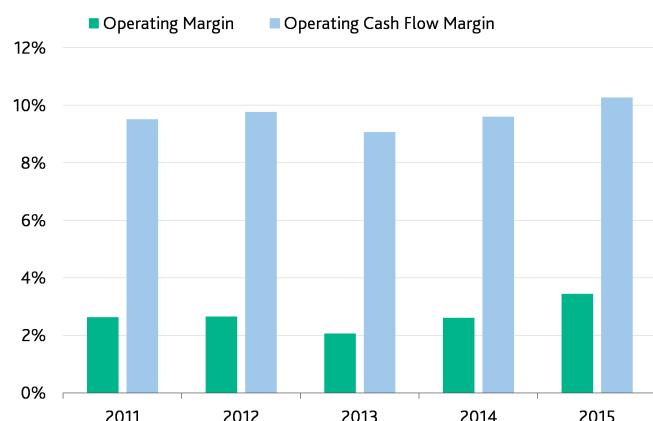
Source: Moody's Investors Service; data prior to 2011 are from different sample sets, however the eight years of data still accurately reflect trends over this period

Strong annual and three-year annual compound revenue growth rates underscore sector's stability

- » The annual revenue growth rate spiked to a six-year high of 7.5% and continued to outpace the annual expense growth rate.
- » For the first time since FY 2011, the three-year operating revenue CAGR of 5.8% outpaced three-year expense CAGR.
- » Stronger annual revenue growth reflected benefits from consolidation in the sector, gains in insurance coverage and favorable utilization trends. However, growth will slow because year-over-year declines in bad debt have slowed, health insurance exchanges are showing signs of stress, expenses are rising with higher drug costs and weaker volume trends reported in the first half of FY 2016.

Exhibit 2

Strong Margins Evidence Sector Stability



Source: Moody's Investors Service

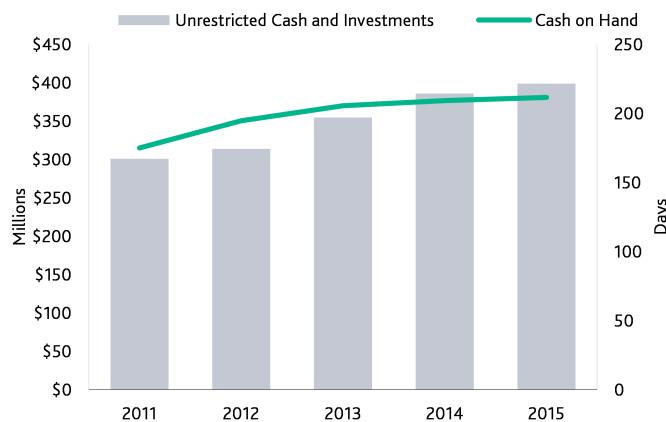
Growth rates of absolute operating income, operating cashflow, and profitability margins surpassed historic levels

- » Following several years of little or no growth, the absolute operating income and operating cash-flow grew 16.7% and 11.0%, respectively. However, the growth rates were not as robust as seen in the FY 2015 preliminary medians reflecting lower volumes in the latter part of FY 2015.
- » Careful alignment of revenue and expense growth, greater insurance coverage and good volume growth translated into a notable up tick in operating and operating cash-flow margins to 3.4% and 10.3%, respectively.
- » Margins should moderate given tightening reimbursement, increasing pension expense, exhausted cost-cutting measures and expectations of slowed revenue growth.

This publication does not announce a credit rating action. For any credit ratings referenced in this publication, please see the ratings tab on the issuer/entity page on www.moodys.com for the most updated credit rating action information and rating history.

Exhibit 3

Modest Absolute Gains in Unrestricted Cash and Investments Lead to Static Expense Cushion



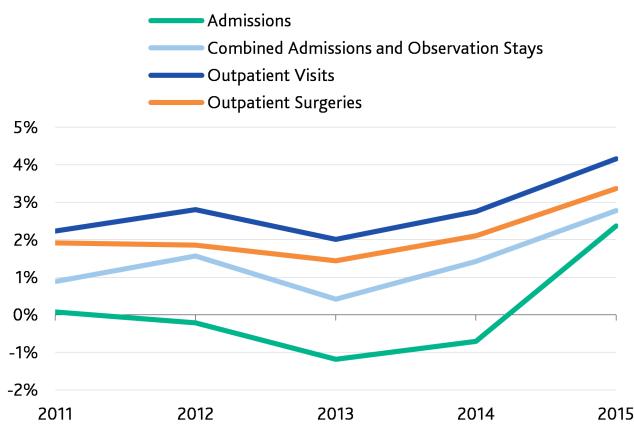
Source: Moody's Investors Service

Improvement in liquidity was modest and days cash on hand flat despite upward trend in margins

- » With a slower growth rate in absolute liquidity of 7.1% as compared to double-digit levels the last two years, days cash on hand showed no growth and remained relatively flat at 211.8 days.
- » Liquidity measures tapered despite strong revenue and operating metrics and a modest level of capital spending, as evidenced by capital spending ratio of 1.1 times. This dynamic reflects the overall trend of weak second-half investment market performance in 2015.
- » Strengthening of absolute and relative balance sheet measures will narrow again in FY 2016 as growth slows in revenue, demand and profitability.

Exhibit 4

Sharp Growth Across All Utilization Measures

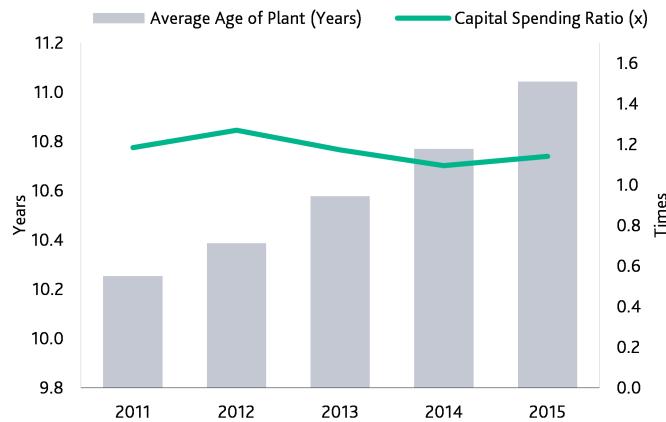


Source: Moody's Investors Service

Utilization measures showed improved growth rates as uninsured population declined

- » Combined inpatient admissions and observation stays grew 2.8% in the FY 2015 medians after a trend of low and variable growth over the last several years. The annual growth rate for inpatient admissions was positive, at 2.7%, for the first time since FY 2011.
- » Consolidation in the sector, benefits from gains in insurance coverage and continued aging of the population drove stronger growth rates.
- » Demand trends will level off with lighter flu season seen in early FY 2016, insurance exchange products exhibiting stress and rising deductibles and co-pays that may thwart demand for electives.

Exhibit 5

Average Age of Plant Rose Even As Capital Spending Exceeded Depreciation

Source: Moody's Investors Service

Hospitals shied away from heavy investment in traditional bricks and mortar given challenges that face the sector while demand for information technology increased

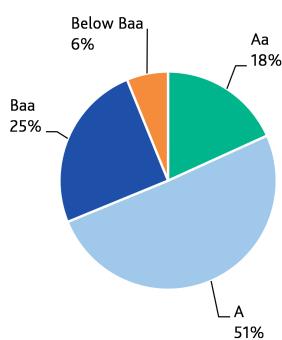
- » After moderating from a high point in FY 2012, the capital spending ratio rose very modestly in FY 2015 but continues to exceed annual depreciation levels.
- » The average age of plant has risen in each of the last five years. However, hospitals report spending as much as one-third of their annual capital budgets on information technology, which is often recognized as an operating expense and therefore not captured in traditional capital spending measures.
- » Traditional capital investment will remain restrained, resulting in an increased median age of plant, as hospitals will be deliberate and cautious in funding infrastructure.

Basis for Medians

The medians are based on an analysis of audited 2015 financial statements for 340 freestanding hospitals, single-state health systems, and multi-state healthcare systems (see Exhibit 6) that are eligible to be included in the medians, representing 81% of all rated healthcare entities. Entities not eligible to be included in the medians include children's hospitals, hospitals for which five years of data are not available, and certain specialty hospitals (e.g. cancer centers). Moody's currently rates 422 unique not-for-profit hospitals (excluding guarantees) with approximately \$167 billion of rated debt outstanding. The median rating for the sector is A2. The medians are the outcome of a complex rating process that incorporates a broad variety of quantitative and qualitative factors. As such, there is a wide range of values for individual ratios within each rating category. We do not assign an organization's precise rating level simply by comparing its ratios to medians, but rather weigh core credit variables over time as well as in relation to broad variables in the industry.

Exhibit 6

Distribution of Ratings for Organizations in the Medians Sample



Source: Moody's Investors Service

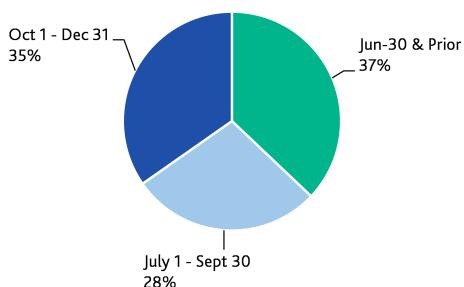
Each year, the entire five-year range of medians is newly computed from a unique set of healthcare entities. The exact set of hospitals used to calculate the medians in any particular year changes from year to year. Changes to the organizations comprising the data are due to a number of factors, including: the addition of new ratings; mergers and acquisitions; the withdrawal of ratings; the occurrence of events that cause an organization's results to be unusual; and the absence of five years of consistent data. For these reasons, historical median results are likely to change somewhat from year to year.

In the appendices beginning on page 6, we present the medians in several formats including: by analytical indicator (Appendix 1); by year for five years, 2011- 2015 (Appendix 2); by broad rating category for 2015 (Appendix 3); and by alphanumeric rating category for 2015 (Appendix 4).

The 340 organizations represented in the medians have a variety of fiscal-year end (FYE) dates (see Exhibit 7) that, in a year of changing economic conditions, affect the medians. For example, hospitals with fiscal year ends near the beginning of the calendar year would have been less impacted by changes in market values of investments held than those with later fiscal year ends.

Exhibit 7

Distribution of FYE Dates Organizations Included in the Medians Sample



Source: Moody's Investors Service

Appendix 1 - Analytical Indicators

	2013	2014	2015
Reimbursement Methods (% of net patient revenue) [1]			
Traditional Capitation (per member per month) (%)	1.63	1.66	1.66
DRG (%)	41.0	40.1	41.3
Percent of charges (%)	19.4	18.1	17.9
Fee schedule (%)	23.3	26.0	27.1
Per diem (%)	4.0	3.5	3.6
Risk based (%)	1.6	2.0	2.1
Other (%)	6.0	5.4	5.2
Sources Of Revenue (% of net patient revenue)			
Inpatient revenue (% of net patient revenue)	51.2	49.7	49.1
Outpatient revenue (% of net patient revenue)	48.5	50.2	50.7
Other Payor Mix Data (% of gross revenue)			
Single largest payor, excluding Medicare and Medicaid (% of gross revenue)	15.0	15.0	15.3
Number of Covered Lives			
Medicare (Number of covered lives)	27,498	30,538	28,806
Medicaid (Number of covered lives)	28,107	34,792	39,527
Commercial (Number of covered lives)	21,890	24,000	28,317
Hospital Utilization Data			
Unique patients	164,304	166,157	183,546
Total case mix index	1.4	1.5	1.5
Number of employed physicians	147	154	170
Active medical staff (independent and employed)	596	592	628

[1] Data do not sum to 100% because each entry is a separately calculated median

Source: Moody's Investors Service

Appendix 2 - Freestanding Hospitals, Single-State, and Multi-State Healthcare Systems, Medians Fiscal Years 2011-2015 [1]

All Ratings	2011	2012	2013	2014	2015
Sample Size	340	340	340	340	340
Utilization [2]					
Maintained Beds	509	513	519	523	534
Admissions	26,797	26,687	26,703	26,942	27,735
Observation Stays	5,006	5,845	6,500	7,237	7,950
Combined Admissions and Observation Stays [3]	33,249	33,175	33,557	35,149	36,401
Patient Days	132,360	131,945	135,795	134,001	136,028
Medicare Case Mix Index	1.61	1.61	1.64	1.68	1.68
Average Length of Stay (Days)	4.7	4.6	4.7	4.7	4.7
Maintained Bed Occupancy (%)	65.6	63.5	63.5	63.5	64.3
Emergency Room Visits	88,584	91,506	95,301	99,113	103,743
Outpatient Visits	362,500	385,416	398,848	410,034	428,462
Outpatient Surgeries	12,227	12,289	13,026	13,604	14,267
Financial Performance (\$000)					
Net Patient Revenues	629,456	588,820	621,832	662,312	703,513
Total Operating Revenue	633,017	669,994	699,536	737,800	772,902
Interest Expense	8,979	9,753	10,006	10,366	10,190
Depreciation and Amortization Expense	36,159	37,017	40,746	41,151	41,756
Total Operating Expenses	619,818	641,395	687,309	695,821	744,812
Income from Operations	17,761	17,123	11,954	16,818	24,802
Operating Cash Flow	61,477	62,111	59,256	67,069	75,697
Excess of Revenue Over Expenses	38,687	38,653	34,190	41,424	45,860
Net Revenue Available for Debt Service	79,980	81,317	81,753	90,782	95,498
Debt Service	18,201	19,198	19,206	19,698	20,655
Additions to Property, Plant, & Equipment	44,319	46,751	48,585	47,666	50,588
Balance Sheet (\$000)					
Unrestricted Cash and Investments	301,052	313,870	354,973	386,018	399,112
Total Debt	254,044	260,417	270,834	273,892	291,191
Total Adjusted Debt	352,502	379,474	385,156	395,221	414,483
Net Property, Plant, and Equipment	331,078	351,730	366,867	400,602	410,727
Unrestricted Net Assets	380,399	395,109	448,066	499,007	511,261
Monthly Liquidity [4]	295,959	307,652	346,311	375,900	392,441
Annual Liquidity	308,329	333,968	369,135	391,628	413,178

All Ratings	2011	2012	2013	2014	2015
Sample Size	340	340	340	340	340
Key Ratios					
Operating Margin	2.6%	2.7%	2.1%	2.6%	3.4%
Excess Margin	5.3%	5.6%	5.2%	5.8%	6.1%
Operating Cash Flow Margin	9.5%	9.8%	9.1%	9.6%	10.3%
Cash on Hand (Days)	175.1	194.8	205.6	209.5	211.8
Unrestricted Cash and Investments to Total Debt	123.3%	129.5%	136.7%	151.5%	154.0%
Unrestricted Cash and Investments to Total Adjusted Debt	95.6%	97.4%	109.4%	117.5%	117.9%
Maximum Annual Debt Service Coverage (x)	4.4	4.4	4.2	4.6	4.8
Annual Debt Service Coverage (x)	4.7	4.8	4.6	5.1	5.2
Total Debt-to-Cash Flow (x)	2.9	3.0	3.1	2.8	2.7
Total Debt-to-Total Operating Revenue	36.5%	38.5%	38.7%	36.9%	34.5%
Annual Operating Revenue Growth Rate	5.3%	5.5%	4.1%	5.3%	7.5%
Annual Operating Expense Growth Rate	5.2%	5.7%	4.8%	4.7%	6.6%
3 Year Operating Revenue CAGR	5.6%	5.2%	5.0%	5.4%	5.8%
3 Year Operating Expense CAGR	5.4%	5.3%	5.5%	5.4%	5.5%
Total Debt-to-Capitalization	39.3%	38.4%	35.4%	33.8%	33.7%
Current Ratio (x)	2.0	1.9	1.9	2.0	2.0
Cushion Ratio (x)	16.1	17.3	17.6	19.5	20.6
Return on Assets	4.8%	4.6%	4.1%	4.5%	4.8%
Accounts Receivable (Days)	45.3	50.3	49.9	49.7	48.4
Average Payment Period (Days)	58.9	64.2	63.5	64.2	64.3
Capital Spending Ratio (x)	1.2	1.3	1.2	1.1	1.1
Average Age of Plant (Years)	10.3	10.4	10.6	10.8	11.0
Monthly Liquidity to Demand Debt	334.5%	341.9%	370.8%	388.3%	399.7%
Annual Liquidity to Demand Debt	372.5%	394.6%	411.5%	437.2%	466.5%
Demand Debt as a % of Total Direct Debt	35.4%	34.5%	34.6%	35.9%	35.8%
Cash to Demand Debt	384.6%	419.8%	437.3%	458.5%	476.5%
Monthly Liquidity to Total Cash and Investments	96.5%	96.0%	95.8%	95.0%	94.2%
Patient Revenue Sources by Gross Revenue (%) [5]					
Total Medicare	43.3%	43.7%	44.3%	44.8%	45.1%
Total Medicaid	13.1%	13.1%	13.0%	13.7%	14.4%
Total Commercial	33.9%	33.4%	32.4%	32.5%	32.0%
Total Self Pay & Other	7.7%	7.7%	7.9%	7.0%	5.9%

[1] Financial data are based on 340 freestanding hospitals, single-state, and multi-state healthcare systems. Ratings are as of 7/15/2016.

[2] Utilization based on smaller sample size where five years of consistent data are available.

[3] Combined Admissions and Observation Stays is a separately calculated median and does not equal the sum of median Admissions and median Observation Stays.

[4] Monthly and Annually Liquidity statistics are based on smaller sample size where five years of consistent data are available.

[5] Payor Mix columns do not sum to 100% because each entry is a separately calculated median.

Source: Moody's Investors Service

Appendix 3 - Freestanding Hospitals, Single-State, and Multi-State Healthcare Systems, Medians by Broad Rating Category, Fiscal Year 2015 [1]

All Ratings	2015	Aa	A	Baa	Below Baa
Sample Size	340	62	172	85	21
Utilization [2]					
Maintained Beds	534	1677	526	303	221
Admissions	27,735	76,988	27,735	15,436	9,066
Observation Stays	7,950	24,266	8,080	5,459	2,023
Combined Admissions and Observation Stays [3]	36,401	103,065	37,269	19,718	12,092
Patient Days	136,028	367,277	134,929	69,591	57,695
Medicare Case Mix Index	1.68	1.79	1.68	1.65	1.49
Average Length of Stay (Days)	4.7	4.9	4.6	4.6	4.7
Maintained Bed Occupancy (%)	64.3	66.0	64.7	61.7	65.7
Emergency Room Visits	103,743	312,169	106,455	65,092	52,197
Outpatient Visits	428,462	1,215,926	432,135	292,895	188,339
Outpatient Surgeries	14,267	38,082	14,339	8,429	5,515
Financial Performance (\$000)					
Net Patient Revenues	703,513	2,576,000	710,285	426,528	323,920
Total Operating Revenue	772,902	3,190,958	783,235	437,331	348,046
Interest Expense	10,190	31,600	10,876	6,985	5,798
Depreciation and Amortization Expense	41,756	153,175	44,844	21,257	15,753
Total Operating Expenses	744,812	3,016,459	751,472	432,473	369,127
Income from Operations	24,802	156,733	28,125	7,025	741
Operating Cash Flow	75,697	356,556	79,814	35,911	20,187
Excess of Revenue Over Expenses	45,860	271,212	52,061	16,944	3,475
Net Revenue Available for Debt Service	95,498	454,809	101,892	43,778	28,202
Debt Service	20,655	53,507	21,096	12,507	11,105
Additions to Property, Plant, & Equipment	50,588	203,327	53,160	22,803	13,567
Balance Sheet (\$000)					
Unrestricted Cash and Investments	399,112	2,143,595	462,560	187,191	106,922
Total Debt	291,191	1,040,514	290,144	151,950	123,455
Total Adjusted Debt	414,483	1,398,826	400,813	220,408	239,391
Net Property, Plant, and Equipment	410,727	1,551,731	410,727	204,161	118,165
Unrestricted Net Assets	511,261	2,513,537	585,629	213,908	70,301
Monthly Liquidity [4]	392,441	1,738,341	413,540	177,505	79,111
Annual Liquidity	413,178	2,064,406	440,918	185,540	106,922

All Ratings	2015	Aa	A	Baa	Below Baa
Sample Size	340	62	172	85	21
Key Ratios					
Operating Margin	3.4%	5.0%	3.9%	1.8%	0.1%
Excess Margin	6.1%	8.4%	6.7%	4.1%	1.1%
Operating Cash Flow Margin	10.3%	10.6%	10.8%	8.7%	6.5%
Cash on Hand (Days)	211.8	276.6	227.5	161.0	98.8
Unrestricted Cash and Investments to Total Debt	154.0%	222.0%	158.9%	105.6%	72.8%
Unrestricted Cash and Investments to Total Adjusted Debt	117.9%	184.8%	125.5%	88.1%	51.0%
Maximum Annual Debt Service Coverage (x)	4.8	7.0	5.1	3.7	2.2
Annual Debt Service Coverage (x)	5.2	8.2	5.5	3.7	2.3
Total Debt-to-Cash Flow (x)	2.7	2.2	2.6	3.3	5.0
Total Debt-to-Total Operating Revenue	34.5%	30.6%	35.2%	36.8%	37.0%
Annual Operating Revenue Growth Rate	7.5%	9.0%	7.6%	6.0%	6.5%
Annual Operating Expense Growth Rate	6.6%	7.7%	6.6%	5.8%	5.5%
3 Year Operating Revenue CAGR	5.8%	7.4%	6.0%	4.8%	4.3%
3 Year Operating Expense CAGR	5.5%	6.9%	5.7%	4.8%	2.8%
Total Debt-to-Capitalization	33.7%	27.9%	32.8%	41.4%	53.2%
Current Ratio (x)	2.0	1.6	2.0	2.2	2.1
Cushion Ratio (x)	20.6	32.4	21.0	13.2	6.9
Return on Assets	4.8%	6.0%	5.1%	3.4%	1.1%
Accounts Receivable (Days)	48.4	48.5	48.6	47.4	48.9
Average Payment Period (Days)	64.3	74.1	61.3	60.9	61.1
Capital Spending Ratio (x)	1.1	1.3	1.2	1.0	0.8
Average Age of Plant (Years)	11.0	9.8	11.0	11.7	12.7
Monthly Liquidity to Demand Debt	399.7%	413.5%	399.1%	302.3%	527.0%
Annual Liquidity to Demand Debt	466.5%	535.7%	429.3%	345.0%	527.0%
Demand Debt as a % of Total Direct Debt	35.8%	40.7%	31.8%	38.1%	21.7%
Cash to Demand Debt	476.5%	561.7%	439.8%	352.2%	527.0%
Monthly Liquidity to Total Cash and Investments	94.2%	84.0%	94.1%	98.0%	100.0%
Patient Revenue Sources by Gross Revenue (%) [5]					
Total Medicare	45.1%	42.4%	45.7%	45.8%	45.3%
Total Medicaid	14.4%	15.1%	14.1%	14.0%	18.9%
Total Commercial	32.0%	35.5%	31.6%	30.5%	27.4%
Total Self Pay & Other	5.9%	6.4%	5.8%	5.9%	7.5%

[1] Financial data are based on 340 freestanding hospitals, single-state, and multi-state healthcare systems. Ratings are as of 7/15/2016.

[2] Utilization based on smaller sample size where five years of consistent data are available.

[3] Combined Admissions and Observation Stays is a separately calculated median and does not equal the sum of median Admissions and median Observation Stays.

[4] Monthly and Annually Liquidity statistics are based on smaller sample size where five years of consistent data are available.

[5] Payor Mix columns do not sum to 100% because each entry is a separately calculated median.

Source: Moody's Investors Service

Appendix 4 - Freestanding Hospitals, Single-State, and Multi-State Healthcare Systems, Medians by Numerical Rating Category, Fiscal Year 2015 [1]

	All Ratings	Aa2	Aa3	A1	A2	A3	Baa1	Baa2	Baa3	Below Baa
Sample Size	340	19	42	52	67	53	33	39	13	21
Utilization [2]										
Maintained Beds	534	2,380	1,530	633	522	402	402	227	282	221
Admissions	27,735	123,810	71,860	30,351	27,896	23,942	23,812	13,573	12,728	9,066
Observation Stays	7,950	36,507	21,372	8,360	9,559	5,031	5,977	4,404	3,908	2,023
Combined Admissions and Observation Stays [3]	36,401	134,395	86,269	39,279	39,585	29,567	31,219	17,780	16,908	12,092
Patient Days	136,028	599,167	327,773	152,369	138,941	110,116	103,261	54,672	56,836	57,695
Medicare Case Mix Index	1.68	1.75	1.80	1.73	1.67	1.66	1.68	1.61	1.54	1.49
Average Length of Stay (Days)	4.7	5.0	4.9	4.8	4.6	4.6	4.8	4.5	4.7	4.7
Maintained Bed Occupancy (%)	64.3	67.1	64.5	63.7	64.3	68.0	64.2	60.0	56.4	65.7
Emergency Room Visits	103,743	377,967	268,344	116,377	113,318	95,484	77,205	53,617	62,841	52,197
Outpatient Visits	428,462	1,577,788	1,024,052	486,523	396,829	424,951	318,322	248,206	386,773	188,339
Outpatient Surgeries	14,267	47,427	27,653	16,913	13,271	11,521	12,057	7,235	8,275	5,515
Financial Performance (\$000)										
Net Patient Revenues	703,513	3,262,654	2,102,611	977,141	672,361	570,154	489,157	287,604	411,600	323,920
Total Operating Revenue	772,902	4,260,792	2,834,771	1,065,389	715,242	580,416	526,756	302,656	427,742	348,046
Interest Expense	10,190	41,071	25,623	13,654	9,666	10,152	8,383	5,639	7,269	5,798
Depreciation and Amortization Expense	41,756	197,003	113,125	56,460	37,444	29,974	28,129	14,897	19,696	15,753
Total Operating Expenses	744,812	3,922,180	2,608,174	996,230	700,035	562,029	503,499	315,944	432,473	369,127
Income from Operations	24,802	221,432	132,517	54,738	21,793	17,696	18,349	3,183	1,786	741
Operating Cash Flow	75,697	500,080	305,492	134,446	65,346	56,228	56,768	28,579	30,583	20,187
Excess of Revenue Over Expenses	45,860	407,469	214,833	94,646	40,206	32,934	27,858	11,621	7,534	3,475
Net Revenue Available for Debt Service	95,498	681,222	403,810	169,669	86,747	74,677	67,570	35,204	43,778	28,202
Debt Service	20,655	70,277	46,367	25,722	19,728	20,469	15,911	11,480	12,883	11,105
Additions to Property, Plant, & Equipment	50,588	294,586	170,201	71,547	51,320	38,619	27,506	18,025	24,280	13,567
Balance Sheet (\$000)										
Unrestricted Cash and Investments	399,112	3,547,341	1,927,003	655,384	399,159	307,057	218,636	156,467	176,984	106,922
Total Debt	291,191	1,448,684	875,072	402,968	255,770	230,166	189,698	115,192	145,205	123,455
Total Adjusted Debt	414,483	1,773,139	1,079,890	514,052	306,104	310,359	261,500	158,501	166,981	239,391
Net Property, Plant, and Equipment	410,727	1,963,873	1,257,121	593,485	339,865	296,260	215,209	150,586	155,016	118,165
Unrestricted Net Assets	511,261	3,961,644	2,199,707	792,022	515,388	354,136	233,712	173,112	196,131	70,301
Monthly Liquidity [4]	392,441	2,659,847	1,510,611	597,788	392,425	298,584	218,090	162,253	111,232	79,111
Annual Liquidity	413,178	3,541,017	1,947,406	615,593	398,077	301,807	224,429	172,378	133,080	106,922

	All Ratings	Aa2	Aa3	A1	A2	A3	Baa1	Baa2	Baa3	Below Baa
Sample Size	340	19	42	52	67	53	33	39	13	21
Key Ratios										
Operating Margin	3.4%	6.1%	4.6%	4.9%	3.7%	3.1%	3.2%	1.5%	0.9%	0.1%
Excess Margin	6.1%	10.3%	7.9%	8.2%	6.7%	5.4%	5.5%	3.7%	2.6%	1.1%
Operating Cash Flow Margin	10.3%	12.2%	10.3%	11.8%	11.4%	10.0%	9.3%	8.1%	8.2%	6.5%
Cash on Hand (Days)	211.8	362.7	266.2	255.0	222.9	187.4	171.3	152.0	132.5	98.8
Unrestricted Cash and Investments to Total Debt	154.0%	258.3%	201.1%	180.7%	151.7%	139.0%	111.2%	94.8%	97.2%	72.8%
Unrestricted Cash and Investments to Total Adjusted Debt	117.9%	205.5%	149.1%	141.8%	124.1%	114.4%	91.7%	89.3%	76.2%	51.0%
Maximum Annual Debt Service Coverage (x)	4.8	8.0	6.8	6.0	4.8	4.2	3.9	3.4	3.7	2.2
Annual Debt Service Coverage (x)	5.2	9.4	7.9	6.7	5.2	4.5	4.1	3.3	3.5	2.3
Total Debt-to-Cash Flow (x)	2.7	2.0	2.3	2.3	2.7	2.8	2.9	3.8	3.3	5.0
Total Debt-to-Total Operating Revenue	34.5%	31.3%	30.5%	31.2%	35.8%	36.2%	36.0%	38.7%	35.0%	37.0%
Annual Operating Revenue Growth Rate	7.5%	7.7%	9.3%	8.9%	7.2%	7.2%	7.4%	5.4%	4.6%	6.5%
Annual Operating Expense Growth Rate	6.6%	7.5%	7.7%	7.0%	6.6%	6.3%	7.1%	5.8%	3.6%	5.5%
3 Year Operating Revenue CAGR	5.8%	6.3%	7.7%	7.2%	5.8%	5.8%	5.6%	5.1%	3.1%	4.3%
3 Year Operating Expense CAGR	5.5%	6.3%	7.4%	6.1%	5.5%	5.5%	5.2%	5.2%	2.2%	2.8%
Total Debt-to-Capitalization	33.7%	25.1%	29.4%	30.6%	33.3%	36.5%	38.8%	43.2%	39.4%	53.2%
Current Ratio (x)	2.0	1.2	1.7	2.2	2.0	1.9	2.2	2.2	2.1	2.1
Cushion Ratio (x)	20.6	42.9	29.3	24.4	20.5	17.4	13.4	13.2	12.5	6.9
Return on Assets	4.8%	6.8%	5.8%	6.3%	4.9%	4.4%	4.9%	2.6%	2.5%	1.1%
Accounts Receivable (Days)	48.4	49.0	48.4	47.7	49.4	48.0	48.6	47.9	44.7	48.9
Average Payment Period (Days)	64.3	87.7	68.4	56.0	64.3	67.9	60.3	58.7	71.5	61.1
Capital Spending Ratio (x)	1.1	1.4	1.2	1.2	1.2	1.2	1.0	1.0	0.8	0.8
Average Age of Plant (Years)	11.0	9.7	10.2	11.1	11.0	11.0	11.8	11.8	11.6	12.7
Monthly Liquidity to Demand Debt	399.7%	392.4%	414.3%	379.7%	417.2%	387.2%	366.5%	272.5%	515.8%	527.0%
Annual Liquidity to Demand Debt	466.5%	579.9%	490.1%	411.1%	429.3%	444.6%	366.5%	288.0%	538.5%	527.0%
Demand Debt as a % of Total Direct Debt	35.8%	44.2%	37.0%	35.9%	31.5%	26.4%	34.2%	50.1%	20.8%	21.7%
Cash to Demand Debt	476.5%	622.8%	524.2%	412.0%	435.5%	492.6%	413.1%	284.2%	691.7%	527.0%
Monthly Liquidity to Total Cash and Investments	94.2%	73.4%	88.1%	86.0%	94.8%	98.9%	100.0%	97.8%	95.8%	100.0%
Patient Revenue Sources by Gross Revenue (%) [5]										
Total Medicare	45.1%	42.5%	42.3%	46.5%	45.6%	46.6%	46.1%	45.9%	44.4%	45.3%
Total Medicaid	14.4%	14.1%	16.0%	13.5%	14.0%	15.3%	13.1%	13.4%	17.5%	18.9%
Total Commercial	32.0%	37.0%	35.0%	32.3%	31.9%	31.0%	29.3%	32.0%	30.2%	27.4%
Total Self Pay & Other	5.9%	7.0%	5.7%	6.2%	5.6%	4.6%	6.0%	5.2%	6.1%	7.5%

[1] Financial data are based on 340 freestanding hospitals, single-state, and multi-state healthcare systems. Ratings are as of 7/15/2016.

[2] Utilization based on smaller sample size where five years of consistent data are available.

[3] Combined Admissions and Observation Stays is a separately calculated median and does not equal the sum of median Admissions and median Observation Stays.

[4] Monthly and Annually Liquidity statistics are based on smaller sample size where five years of consistent data are available.

[5] Payer Mix columns do not sum to 100% because each entry is a separately calculated median.

Source: Moody's Investors Service

Moody's Healthcare Ratio Definitions

Ratio	Computation
3 Year Operating Revenue CAGR	(Operating Revenue Current Year divided by Operating Revenue Current Year minus 3) \wedge (1/3) - 1
Accounts Receivable (Days)	(Net patient accounts receivable x 365) / net patient revenue
Annual Debt-Service Coverage (x)	Net revenue available for debt service / (principal payments + interest expense)
Annual Liquidity	The dollar amount of total cash and investments that can be liquidated in one year or less. Annual liquidity is inclusive of monthly liquidity.
Annual Liquidity to Demand Debt	Annual Liquidity divided by Demand Debt
Average Age of Plant (Years)	Accumulated depreciation / depreciation expense
Average Payment Period (Days)	(Total current liabilities x 365) / (total operating expenses - depreciation and amortization expenses)
Capital Spending Ratio (x)	(Additions to PP&E / depreciation expense)
Cash on Hand (Days)	(Unrestricted cash and investments x 365) / (total operating expenses - depreciation and amortization expenses)
Unrestricted Cash and Investments to Total Debt	Unrestricted cash and investments/ (long term debt + short term debt)
Cash to Demand Debt	Unrestricted Cash and Investments divided by Demand Debt
Unrestricted Cash and Investments to Total Adjusted Debt	Unrestricted cash and investments divided by Total Adjusted Debt
Current Ratio (x)	Total current assets / total current liabilities
Cushion Ratio (x)	Unrestricted cash and investments / estimated future peak debt service
Total Debt-to-Capitalization (%)	(Long-term debt + short-term debt) / (long-term debt + short-term debt + unrestricted fund balance)
Total Debt-to-Cash Flow (x)	(Long-term debt + short-term debt) / (excess of revenues over expenses + depreciation and amortization expenses + interest expense)
Total Debt-to-Total Operating Revenue	(Long-term debt + short-term debt) / total operating revenue
Excess Margin (%)	(Total operating revenue - total operating expenses + nonoperating income) / (total operating revenue + non-operating income)
Maximum Annual Debt Service Coverage (x)	Net revenue available for debt service / estimated future peak principal payments and interest expense
Medicare Case-Mix Index	Measurements comparing acuity of Medicare patients among hospitals
Monthly Liquidity	The dollar amount of total cash and investments that can be liquidated in one month or less.
Monthly Liquidity to Demand Debt	Monthly liquidity divided by Demand Debt
Monthly Liquidity to Total Cash and Investments	Monthly Liquidity divided by Total Cash and Investments
Net Debt (\$000)	Total debt outstanding - trustee-held bond funds
Net Revenue Available for Debt Service	(Total operating revenue - total operating expenses + nonoperating income) + depreciation and amortization expenses + interest expense
Operating Cash Flow Margin (%)	(Total operating revenue - total operating expenses + interest expense + depreciation and amortization expenses) / total operating revenue
Operating Margin (%)	(Total operating revenue - total operating expenses) / total operating revenue
Return on Assets (%)	Excess of revenues over expenses / total assets
Total Adjusted Debt	Direct debt plus operating leases, and pension obligation, if applicable.
Unrestricted Cash and Investments (\$000)	Unrestricted cash + short-term investments + board-designated cash and investments

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REPORT NUMBER 1037395

2016 Median Ratios for Nonprofit Hospitals and Healthcare Systems

Special Report

Fiscal 2015 Median Ratios: Stability Across Rating Categories

Amendment

This report, originally published on Sept. 7, 2016, has been amended to reflect a correction to the Rating Outlook of Sky Lakes Medical Center on page 14.

Improved Operating Performance: Median operating profitability metrics improved across all categories in 2015 driven by many of the same factors from 2014; namely, the sector's continued focus on improving operating cost efficiencies, expanded coverage from the Affordable Care Act (ACA), and greater focus on revenue cycle improvement and collections. The median operating margin and operating EBITDA margin improved to 3.5% and 10.3%, respectively, in 2015 from 3.0% and 9.7% in the prior year. Moreover, median operating profitability margins (that is, operating and operating EBITDA) improved across all rating categories.

Stable Liquidity: Key median liquidity metrics (days cash on hand, cushion ratio and cash-to-debt) were virtually unchanged from the prior year despite relatively volatile investment markets in the latter half of 2015 and early 2016. Fitch Ratings attributes the stable liquidity metrics to solid cash flow generation, moderate capital spending, and the sector's diversified investment approach. Fitch believes the continued focus on revenue cycle (that is, coding, billing and collections) and extended lead time allowed for a smooth transition to ICD-10 with little disruption to collections and days in accounts receivable.

Moderating Debt Metrics: Overall median leverage ratios were unchanged to slightly improved continuing the sector's longer term trend towards moderating leverage position. The moderation in median debt and leverage ratios reflects the lower capital demand, a favorable interest rate environment, and moderate revenue growth and improved profitability. The increase in overall median debt-to-capitalization to 38.4% in 2015 from 36.7% in 2014 is likely a result of lower corporate discount rates applicable to pension assets, rather than increased borrowing.

Challenging Operating Environment: For 2016, Fitch maintained its Stable Rating Outlook, reflecting a slower than anticipated impact of the ACA and the transition to risk-based contracting. However, Fitch has maintained its Negative Sector Outlook, which reflects Fitch's belief that many of the expected pressures from healthcare reform have not been diminished, but have rather been deferred. Pressure on operating performance is more likely in 2016 and beyond due to labor and wage pressures for clinical staff, given the improving U.S. labor market, and the increasing need for clinicians due to the push toward population health management.

Overall Median Rating is 'A': The median rating in Fitch's portfolio remains at 'A'. Approximately 43% of the 246 hospitals and health systems that are used in our median calculations are rated in the 'A' category. The percentage of 'AA' rated entities dropped slightly to 25.6% in 2016 from 26.4% in 2015, as did the percentage of borrowers rated 'BBB' or below, which was at 29.6% in 2016 (compared to 30.6% in 2015). There has been a significant decrease in the percentage of borrowers rated 'BBB' or below over the past 15 years. Fitch believes this trend is likely to continue, with further consolidation as industry pressures prompt lower rated credits to affiliate, align or merge with stronger partners.

Related Research

2016 Outlook: U.S. Nonprofit Hospitals and Healthcare Systems (December 2015)

2015 Median Ratios for Nonprofit Hospitals and Healthcare Systems (August 2015)

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Improved Operating Performance

Operating performance and medians were improved (reflecting the 2015 operating year) compared to the prior year and represents the second consecutive year of improvement in operations. However, unlike last year, the improvement in operating performance was realized across all rating categories, rather than concentrated at the 'A' and 'AA' levels. Fitch believes the sector's continued focus on improving both clinical and non-clinical efficiencies continues to help blunt the impact of compressed commercial rate increases and, little, if any, net rate increases from Medicare and Medicaid. Additionally, while high deductible health plans have become more prevalent, management teams have become more adept at managing the seasonality of patient volumes. The investment in and focus on billing, coding and collections continue to reduce denials, improve collections and enhance overall cash flow.

Patient volumes were more stable and revenue growth slowed in 2015 after a sharp increase in 2014 due to the first year of expanded Medicaid coverage. With the expansion in Medicaid eligibility and the cuts to disproportionate share funding beginning on Nov. 1, 2015, several states have expanded or enacted provider tax programs to increase their Medicaid matching funds that could help to offset some of the pressure on reimbursement.

Fitch expects operating performance (and profitability) to be more volatile in 2016, reflecting growth in the Medicare population, CMS's further implementation of value-based reimbursement models (for example, bundled payments) and Medicaid patients accessing more healthcare services. Improvement in the U.S. economy and falling unemployment is causing labor markets in certain areas to tighten, resulting in overall pressure on wages. In addition the movement toward population health management and a growing focus on chronic disease management have increased the competition for, and cost of, nurses in certain markets, including higher agency usage. Combined, clinical and non-clinical wage pressures could negatively impact operating performance in 2016 and beyond.

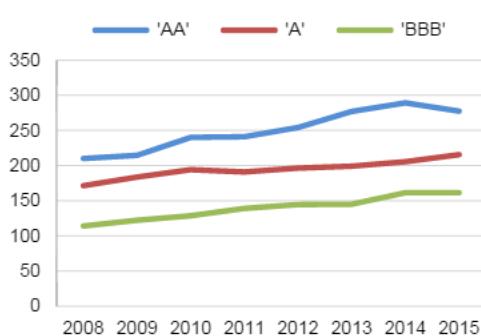
Consolidation and alignment activity remained brisk in 2015. Size, scale, and market presence remain key themes among providers in an effort to extract greater efficiencies, gain contract leverage with payors and suppliers, and build adequate scale and coverage to support population health capabilities and direct to employer contracting. Fitch believes consolidation and alignment activity will remain strong and could accelerate over the next few years due to CMS's value-based payment models, growing Medicare and Medicaid populations, increasing wage pressures, and a more adversarial managed care contracting environment.

Balance Sheet Ratios

Median liquidity metrics were mixed in 2015, reflecting solid operating cash flow and modest capital spending which was tempered by weak investment returns. Year-over-year (YoY) changes among categories are more likely to be a reflection in the composition of the respective category medians rather than a change in operating performance or investment performance.

The overall median for days cash on hand was virtually unchanged at 203.8 days compared to 203.4 days in 2014. Fitch believes liquidity growth in 2015 was hampered by the volatile

Days Cash on Hand



Related Criteria

[U.S. Nonprofit Hospital and Health Systems Rating Criteria \(June 2015\)](#)

[Revenue-Supported Rating Criteria \(June 2014\)](#)

investment markets in 2015 that muted the impact of stronger core operating profitability. 'AA' category median cash on hand was about 12 days lower compared to 2014 (277.4 versus 289.4) while the 'A' category median improved by 10 days (215.5 versus 205.3) and the 'BBB' category median remained virtually unchanged at 161.2.

The overall median for cash to debt eased a bit to 138.5% from 141.8% in the prior year. The median cash-to-debt percentages for the 'AA' and 'BBB' categories were materially unchanged in 2015 at 197.9% and 90.8%, respectively. The 'A' category median cash-to-debt figure improved to 148.6% from 143.7% in 2014 which is consistent with the improvement in 'A' category median days cash on hand. The improvement in 'A' category median days cash on hand and cash-to-debt may reflect the migration of revenue cycle focus and improvement, which started among the larger systems and has trickled down to smaller (based on revenues) providers. Median days in accounts receivables (DAR) for 'A' category borrowers improved to 46.8 from 48.1 in 2014 and 49.9 in 2013. In the meantime, 'AA' median DAR increased to 48.1 from 47.4 and the 'BBB' median DAR declined to 49.0 from 50.6.

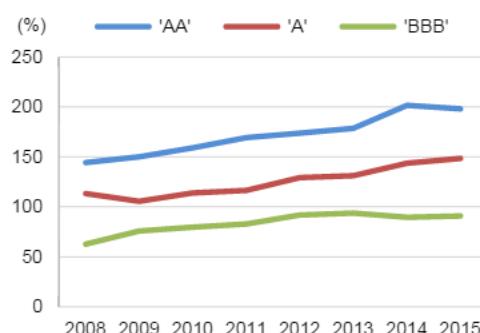
Cushion ratio improved across all rating categories, with the overall median increasing to 18.2x from 17.6x in the prior year. The improvement in overall cushion ratio in 2015 reflects the eighth consecutive year of improvement. The continued improvement reflects a growth in unrestricted cash and investments from operations and investment returns combined with a moderation in leverage and a falling interest rate environment resulting in lower median MADS. Fitch views the sector's long term improvement in liquidity metrics as a key credit strength that provides a substantial financial cushion to absorb the evolving care delivery model and changing reimbursement models.

In 2015, there were a few negative rating actions due to revenue cycle disruptions related to IT conversions with specific borrowers experiencing dramatic interruptions in billing, collection, and revenue realization. However, the concern has been issuer specific and not widespread enough to affect the sector as a whole. Fitch has become somewhat more analytically cautious around IT conversions — particularly around revenue cycle conversions — given the risk of revenue recognition and potential for write offs on accounts receivable leading to a negative impact on the income statement and revenues available for debt service.

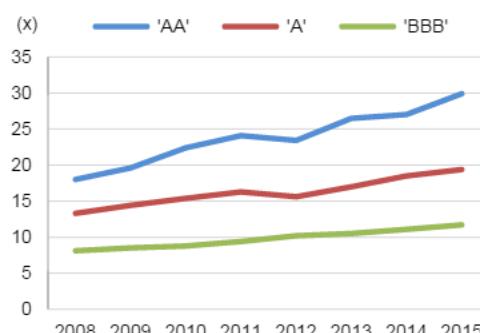
Profitability and Operational Ratios

Overall, median profitability levels posted a second consecutive year of improvement with median operating and operating EBITDA margins of 3.5% and 10.3% compared with 3.0% and 9.7% the prior year. Fitch believes the improving trend reflects the sector's continued focus on operational and clinical improvement and efficiency which began in earnest upon the passage

Cash to Debt

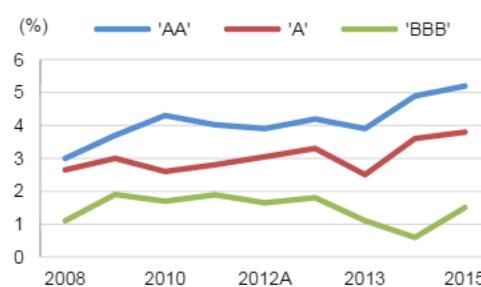


Cushion Ratio



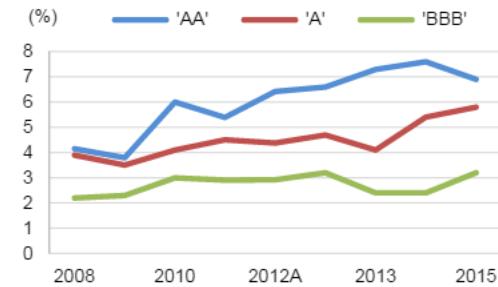
of the ACA in 2010. Investment in IT remains a large line item in hospital and health system capital budget, generally running around 15%–25% annually. However, Fitch believes that for many borrowers the large initial conversion costs as well as training and staffing expense have been absorbed and may be reflected in the improvement in median operating profitability ratios. In addition, Fitch believes the improvement in profitability reflects the benefit from Medicaid expansion (for applicable states) and public exchange enrollment which helped to moderate the rate of increase in bad debt expense (due to increasing copays and deductibles) and lower self-pay.

Operating Margin



Note: 2012A reflects median prior to bad debt reclass.
2012B reflects median after bad debt reclass.

Excess Margin



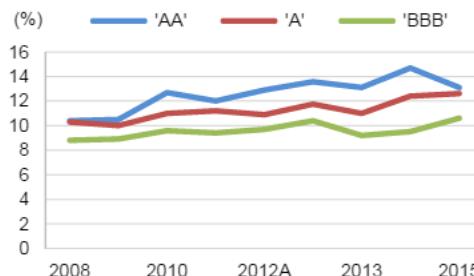
Note: 2012A reflects median prior to bad debt reclass.
2012B reflects median after bad debt reclass.

Interestingly, the improvement in profitability ratios ran across all rating categories with the 'BBB' category median showing the largest improvement. In 2014, 'BBB' category median operating profitability metrics fell, continuing its weakening trend since 2011. In 2015, that trend was reversed with median operating margin increasing to 1.5% from 0.6% and operating EBITDA margin jumping to 8.7% from 7.7% in the prior year. However, the improvement in the 'BBB' category is not indicative of a general improvement among smaller, lower rated providers.

The credits that compose the 'BBB' category median are subject to greater ratings movement both up and down. For example, there are 58 borrowers in this year's median calculation compared to 57 in the prior year and 69 in the 2014 median report. However, during 2015 there were six downgrades of 'BBB' category borrower and 12 upgrades. The ratings actions over the course of 2015 indicate a high degree of ratings volatility among borrowers rated in the 'BBB' category. Moreover, the rating changes among borrowers in the 'BBB' category were evenly spread across states that participated in Medicaid expansion and those that did not.

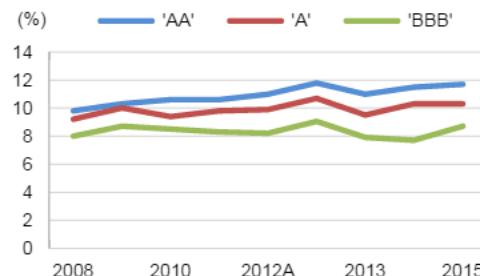
Median excess margin and EBITDA margins improved to 5.2% and 12.2%, respectively, in 2015 from 4.8% and 11.7% in 2014 showing solid benefit from non-operating income sources such as investment returns, contribution, and equity interest in non-consolidated business entities. Median excess and EBITDA margins for 'AA' category borrowers actually declined in 2015 to 6.9% and 13.1%, respectively, from 7.6% and 14.7% in the prior year. Median excess and EBITDA margins for both the 'A' and 'BBB' categories improved in 2015 over 2014 with the 'BBB' category median showing a stronger YoY improvement. Fitch suspects that the decline in 'AA' category median excess and EBITDA margins reflects the higher exposure that 'AA' providers have to equities and hedge funds (asset classes that did not provide much return in 2015).

EBITDA



Note: 2012A reflects median prior to bad debt reclass.
2012B reflects median after bad debt reclass.

Operating EBITDA



Note: 2012A reflects median prior to bad debt reclass.
2012B reflects median after bad debt reclass.

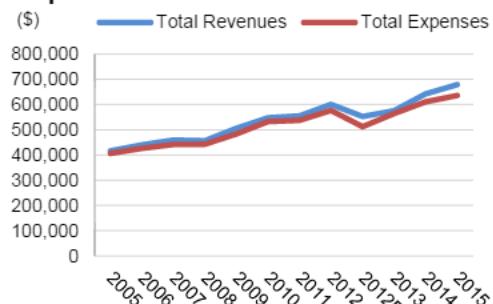
Revenue and Expense Growth

For 2015, overall median revenues rose to \$678.4 million from \$642.1 million in 2014. The YoY (2014–2015) increase of 5.7% is decline from the 11.5% YoY increase experienced in the 2013–2014 timeframe, reflecting the more muted impact from the second year of expanded Medicaid coverage and enrollments on the public insurance exchanges as well as modest rate increases from Medicare and commercial payors. However, expense growth of 4.2% in 2015 was well below the 8.3% increase in 2014. As mentioned above, the continued emphasis on cost containment and efficiency gains continue to pay dividends in operational performance. The low median expense growth is more impressive given the overall increase in pharmacy costs in 2015.

The compound annual growth rate from 2005–2015 was 5.6% and 5.1% for total revenue and total expenses, respectively. In 2008, 2010, and 2013, expense growth rates exceeded revenue growth rates. Fitch believes non-profit health care providers are slower to adjust expenses in response to more abrupt changes in patient volumes as compared to their investor-owned brethren. This is justifiable given the strong liquidity positions of not-for-profit hospitals and health systems rated by Fitch, which allow for a slower and more deliberate approach to operational and staffing changes. It is typical within the sector to bring expenses in line with revenues over a longer (12–18 month) period. Still, expense management continues to be at the forefront of management priorities as reimbursement becomes increasingly tied to value. Fitch views diligent management practices as essential in meeting renewed goals of providing high-quality care at lower cost.

Payer mix erosion is a major concern for the sector as the aging of the U.S. population increases the number of Medicare patients, and Medicaid expansion has increased utilization across more clinical services (rather than emergency services). Reimbursement under Medicare will be further constrained by upcoming reductions to supplemental reimbursement, the ramping up value-based penalties and the ongoing shift towards bundled payments. The continued shifting of health costs by employers onto employees through high copay and deductibles will also affect clinical volumes and bad debt expense. Fitch believes managed care contract negotiations are likely to become increasingly adversarial as providers look to mute the impact of poor governmental reimbursement through their commercial contracts. This, coupled with evidence of payors exiting markets and exchanges, drives premiums higher and

Total Revenues vs. Total Expenses



Note: 2012 reflects median prior to bad debt reclass for comparability.

reimbursement rates lower. Fitch expects most providers to continue developing a strategy based on size, scale, geography and cost structure, and a survival plan that is practical for each specific organization in each market.

Leverage and Capital-Related Ratios

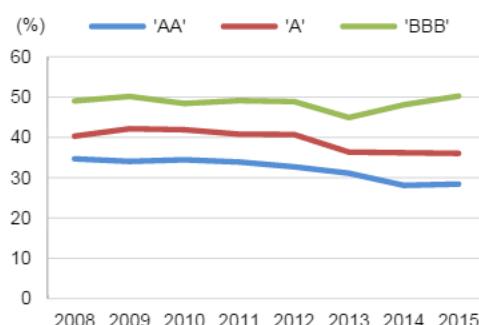
Median leverage metrics exhibited a positive trend for the second consecutive year, with improved MADS coverage and a decline in debt burden. Median coverage of MADS by EBITDA increased to 4.3x from 4.0x while MADS as a percentage of revenues declined slightly to 2.8% from 2.9%. Similarly, median coverage of MADS by operating EBITDA improved to 3.7x from 3.5x in the prior year. Fitch believes the improving trend is largely attributable to the benefits of wider insurance coverage through Medicaid expansion and public health insurance exchanges, continued benefit from cost reduction strategies as well as favorable interest rates that many issuers took advantage of in refunding existing debt or in issuing new debt, particularly direct bank placed debt.

Interestingly, the improvement in median coverage of MADS by EBITDA and operating EBITDA was uniform across the 'AA', 'A', and 'BBB' rating categories. However, 'AA' median coverage of MADS by operating EBITDA showed the strongest gain improving to 5.2x in 2015 from 4.4x in the prior year. The 'A' and 'BBB' category medians improved by 0.4x and 0.2x, respectively. Despite a marginal improvement in median operating EBITDA margin and a compression in median EBITDA margin for the 'AA' category, median MADS coverage metrics improved in 2015 due to the stronger growth in total revenues as compared to the 'A' and 'BBB' category borrowers. Fitch believes this trend reflects a higher revenue growth that accrues to larger health systems through both organic growth and via mergers and acquisitions resulting in stronger absolute cash flows.

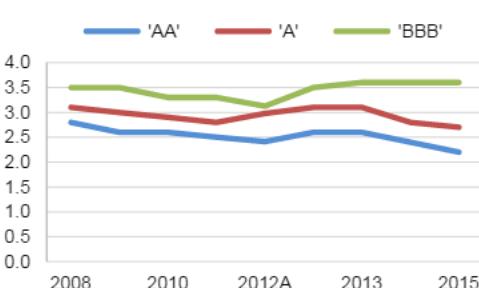
Median debt-to-capitalization increased to 38.4% in 2015 from 36.7% in 2014 and 37.8% in 2013. The erosion in debt-to-capitalization is more a function of the decline in corporate discount rates and increased pension liability impacting fund balances during calendar 2015, rather than the incurrence of additional debt. During 2015 the yield on the 10-year U.S. Treasury Note fell from 2.17% at Dec. 31, 2014 to a low of 1.68% on Jan. 30, 2015, and finished 2015 at 2.27%, suppressing discount rates.

While a sizable number of issuers have come to market in the past year to fund various construction projects, Fitch expects some new money bond issuance activity to continue should the interest rate environment remain favorable, as issuers prefer to shore up cash and investment portfolio balances as a cushion while managing the changing healthcare environment and upcoming IT conversions. Fitch continues to believe larger, integrated systems will continue growing into their debt burden and benefit from economies of scale, geographical diversity, and more sophisticated investment management, possibly furthering divergence among rating categories in the future.

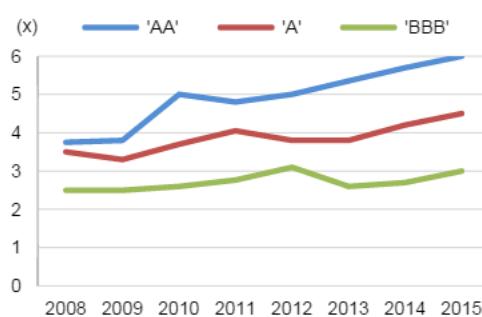
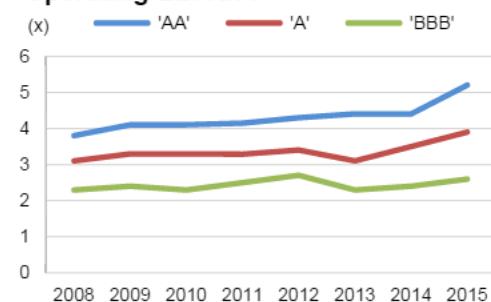
Debt to Capitalization



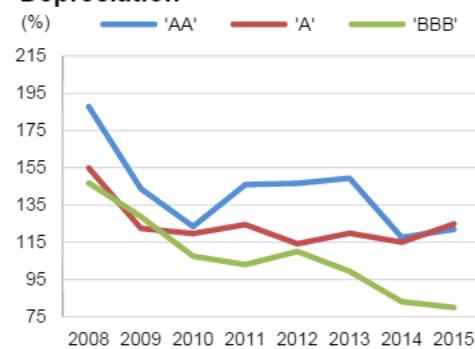
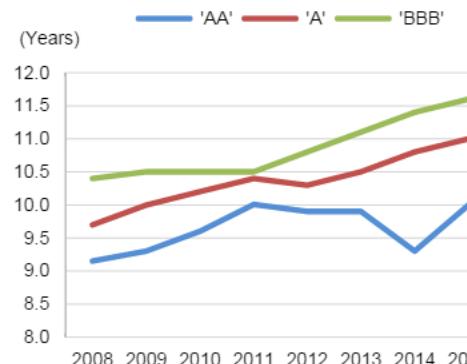
MADS as % of Revenue



Note: 2012A reflects median prior to bad debt reclass.
2012B reflects median after bad debt reclass.

MADS Coverage by EBITDA**MADS Coverage by Operating EBITDA****Stable Capital Spending**

Capital spending increased slightly in 2015 after hitting an eight-year low in 2014. Median capital expenditures as a percentage of depreciation increased to 111.9% in 2015 from 106.6% in 2014. The uptick in capital spending (as percentage of depreciation expense) occurred in both the 'AA' and 'A' categories while capital spending fell even further for the 'BBB' category median to 80.0% from 83.2% in 2014. However, 2014 was the first year 'BBB' issuer spending fell significantly below 100%. Not surprisingly, average age of plant increased across all rating categories.

Capital Expenditures as % of Depreciation**Average Age of Plant**

The increase in average age of plant is driven by an overall shift from investing in brick-and-mortar assets toward expanding outpatient access and developing clinical integration strategies in order to manage the evolving healthcare environment. Major construction projects for inpatient capacity have centered on modernizing existing facilities or building towers to provide private patient rooms to meet changing consumer demands. Fitch does not view the increase in average age of plant as a credit concern and anticipates future investment to continue focusing on expanding patient access points via ambulatory care and outpatient services, optimizing existing inpatient capacity and pursuing alignment and expansion strategies, which may ultimately result in asset mergers.

Rating Actions

Rating actions in 2015 displayed a distinctly positive trend. From Jan. 1 through Dec. 31, 2015, Fitch affirmed 146 ratings, downgraded nine ratings and upgraded 33 ratings. Of the downgraded credits, six ratings carried a Negative Rating Outlook, two carried a Stable Rating Outlook and one was on Rating Watch Negative. Drivers on negative rating actions varied, but included weaker core operating performance due to declining utilization, the inability

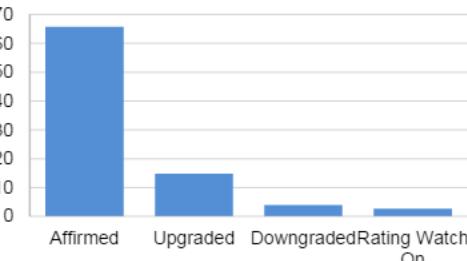
to curb expenditures or a material increase in debt. Of the 33 credits upgraded in 2015, 12 were on a Positive Rating Outlook and 21 had a Stable Rating Outlook. Reasons for upgrade were primarily driven by improved cash flow, growth in liquidity, lower debt, and acquisition by a higher rated credit. Of the 33 upgrades, 14 were 'BBB' category credits (11 'BBB+' rated credits), 13 were 'A' category credits (four 'A+' credits), three were in the 'AA' rating category and three were BIG (i.e. 'BB+' and lower) credits. During 2015, Fitch assigned initial ratings to eight hospital and health systems and withdrew ratings on 15 borrowers.

Rating affirmations with an outlook revision were heavily weighted towards the positive side in 2015, with 20 Stable Outlooks revised to Positive and just five Stable Outlooks revised to Negative.

Rating actions in 2016 were decidedly more balanced compared to 2014 and 2015. Through July 31, there have been 82 rating affirmations, 12 rating downgrades, and 12 rating upgrades. Positive outlook revisions (nine) have slightly exceeded Negative Outlook revisions (eight) during the first seven months of 2016. The upgrades generally reflect strong operating performance resulting in liquidity growth and strong debt service coverage. Conversely, downgrades have resulted from weak operating performance, an increase in debt related to large capital projects and, in two cases, revenue cycle/revenue recognition issues.

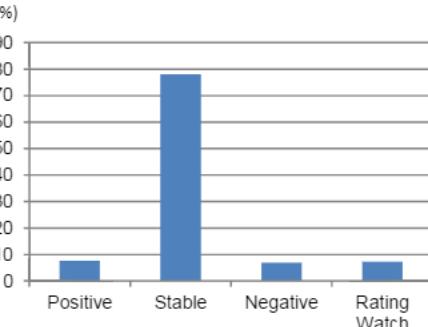
Rating Actions

(Jan. 1, 2015 to Dec. 31, 2015)
(%)

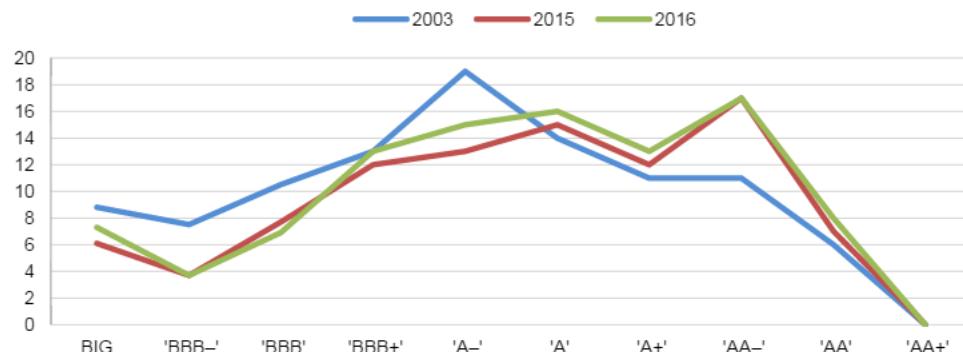


Rating Outlook Distribution

(As of July 15, 2015)
(%)



Ratings Distribution



The migration to value-based reimbursement models continues to lag initial expectations upon the passage of the ACA. However, Fitch believes that the movement to risk-based contracts is likely to pick up speed over the next 36 months, driven by larger and more integrated health systems that have developed in several major metropolitan areas. This transition to value is expected to exacerbate existing pressure on operating margins, particularly for credits with

limited exposure to and experience with, managing risk, and those with smaller revenue bases or higher fixed expenses to spread that risk across.

As stated in our Outlook for 2016 and beyond, Fitch expects further widening of the credit gap as narrow networks and provider-sponsored health plans favor larger systems with a more comprehensive and broad clinical footprint, pressuring providers who lack sufficient market penetration due to limited clinical or geographical breadth.

Nonprofit Hospital and Healthcare System Category Medians — 2016

	Median	'AA'	'A'	'BBB'	Below 'BBB'
Sample Size	246	63	107	58	18
Total Operating Revenue (\$ Mil.)	678,398	2,264,054	633,705	448,099	282,555
Days Cash on Hand	203.8	277.4	215.5	161.2	95.7
Days in Accounts Receivable	47.9	48.1	46.8	49.0	48.0
Cushion Ratio (x)	18.2	29.9	19.4	11.7	6.4
Days in Current Liabilities	65.7	67.3	65.5	64.9	67.7
Cash to Debt (%)	138.5	197.9	148.6	90.8	50.8
Operating Margin (%)	3.5	5.2	3.8	1.5	2.1
Operating EBITDA Margin (%)	10.3	11.7	10.3	8.7	10.5
Excess Margin (%)	5.2	6.9	5.8	3.2	2.2
EBITDA Margin (%)	12.2	13.1	12.6	10.6	10.8
Personnel Costs as % of Total Operating Revenue	53.6	52.0	55.0	54.4	53.1
Bad Debt as % of Patient Revenue	4.4	3.5	4.1	6.4	8.0
EBITDA Debt Service Coverage (x)	4.3	6.0	4.5	3.0	2.7
Operating EBITDA Debt Service Coverage (x)	3.7	5.2	3.9	2.6	2.3
Maximum Annual Debt Service as % of Revenues	2.8	2.2	2.7	3.6	3.8
Debt to EBITDA (x)	3.1	2.5	2.9	4.3	4.9
Debt to Capitalization (%)	38.4	28.4	36.0	50.2	58.5
Average Age of Plant (Years)	10.8	10.0	11.0	11.6	9.8
Capital Expenditures as % of Depreciation Expense	111.9	121.9	124.8	80.0	68.1

EBITDA – Earnings before interest, taxes, depreciation, and amortization.

Nonprofit Hospital and Healthcare System Medians for Investment Grade Ratings — 2016

	AA	AA-	A+	A	A-	BBB+	BBB	BBB-
Sample Size	20	42	32	39	36	32	17	9
Total Operating Revenue (\$ Mil.)	3,167,295	1,759,319	738,316	914,840	530,085	502,607	448,955	360,202
Days Cash on Hand	285.7	276.9	253.8	198.2	191.9	162.8	165.2	136.6
Days in Accounts Receivable	46.9	48.5	44.9	48.4	46.6	48	51.1	47.9
Cushion Ratio (x)	35.3	26.6	26	18.5	15.6	12.5	10.5	10
Days in Current Liabilities	74.3	65.1	63.6	65.7	69	67.4	64.8	57.1
Cash to Debt (%)	243.4	183.3	175.5	137.8	127.8	93.3	73	90.8
Operating Margin (%)	5.1	5.7	5.15	3.5	3.95	2	-0.2	-0.6
Operating EBITDA Margin (%)	11.1	12.3	12.1	10	10.05	9.9	7	7.7
Excess Margin (%)	6.85	6.9	7.4	5.2	5.55	4.2	3	-0.6
EBITDA Margin (%)	12.55	13.85	14.05	11.6	12.2	11.1	9.9	7.7
Personnel Costs as % of Total Operating Revenue	50.75	52.2	55.1	53.6	57	53.5	55.2	56.4
Bad Debt as % of Patient Revenue	3.59	3.48	3.78	4.39	4.23	6.38	5.08	7.76
EBITDA Debt Service Coverage (x)	6.25	6	5.6	4.1	4.1	3.35	2.8	1.9
Operating EBITDA Debt Service Coverage (x)	5.8	4.9	4.7	3.5	3.55	2.8	2.4	1.5
Maximum Annual Debt Service as % of Revenues	2	2.4	2.55	2.9	3	3.4	3.9	3.9
Debt to EBITDA (x)	2.5	2.5	2.45	3.1	3.05	3.55	4.7	5.6
Debt to Capitalization (%)	25.75	29.6	32.25	38.6	39	49.15	51.1	46.6
Average Age of Plant (Years)	10.2	10	11.4	10.8	11	10.8	12.1	13.2
Capital Expenditures as % of Depreciation Expense	126.3	117.55	131	127.6	117.95	83.3	95.8	64.5

EBITDA – Earnings before interest, taxes, depreciation, and amortization. Note: Table excludes the one 'AA+' entity.

Nonprofit Hospital and Healthcare System Overall Medians

(Fiscal Years)

	2004	2008	2009	2010	2011	2012A	2012B	2013	2014	2015
Sample Size	220	227	244	248	251	249	249	243	235	246
Days Cash on Hand	157.8	151.6	166.8	180.5	181.7	183.9	183.9	193.9	203.4	203.8
Days in Accounts Receivable	51.5	48.4	44.7	43.8	45.1	48.5	48.5	49.3	48.2	47.9
Cushion Ratio (x)	11.4	12.0	12.8	13.6	14.3	14.6	14.6	16.4	17.6	18.2
Days in Current Liabilities	64.5	62.8	63.8	63.4	63.5	66.7	66.7	64.8	66.4	65.7
Cash to Debt (%)	99.4	101.3	104.8	112.8	113.0	119.3	119.3	127.7	141.8	138.5
Operating Margin (%)	2.1	2.2	2.8	2.6	2.7	2.9	3.0	2.2	3.0	3.5
Operating EBITDA Margin (%)		8.9	9.5	9.4	9.4	9.5	10.3	9.2	9.7	10.3
Excess Margin (%)	3.7	2.9	2.8	3.9	4.1	4.3	4.6	3.7	4.8	5.2
EBITDA Margin (%)	10.8	9.4	9.3	10.8	10.6	10.9	11.6	10.9	11.7	12.2
Personnel Costs as % of Total Operating Revenue	51.6	50.6	50.2	50.8	50.7	50.7	54.2	55.0	54.4	53.6
Bad Debt as % of Patient Revenue	—	—	—	—	—	—	5.6	5.8	5.3	4.4
EBITDA Debt Service Coverage (x)	3.3	3.1	2.9	3.5	3.8	3.7	3.7	3.5	4.0	4.3
Operating EBITDA Debt Service Coverage (x)	N.A.	2.8	3.0	3.0	3.2	3.3	3.3	3.0	3.5	3.7
Maximum Annual Debt Service as % of Revenues	3.4	3.1	3.1	3.0	2.8	2.9	3.1	3.1	2.9	2.8
Debt to EBITDA (x)	3.7	3.6	3.9	3.4	3.4	3.3	3.3	3.6	3.1	3.1
Debt to Capitalization (%)	42.3	41.6	42.6	42.1	40.8	41.2	41.2	37.8	36.6	38.4
Average Age of Plant (Years)	9.8	9.9	10.0	10.2	10.4	10.4	10.4	10.6	10.6	10.8
Capital Expenditures as % of Depreciation Expense	133.3	154.4	127.1	115.7	127.8	125.7	125.7	115.7	106.6	111.9

N.A. – Not available. EBITDA – Earnings before interest, taxes, depreciation, and amortization. 2012A – Prior to bad debt restatement. 2012B – Following bad debt restatement.

Hospital Ratings

(As of July 15, 2016)

Name	Long-Term Rating	Rating Outlook/Rating Watch
Adventist Health (CA)	A	Stable
Adventist Health System Sunbelt, Inc. (FL)	AA	Stable
Advocate Health Care Network (IL)	AA	Stable
Alexian Brothers Health System (IL)	A-	Stable
Allina Health System (MN)	AA-	Stable
Altru Health System (ND)	A-	Stable
AnMed Health (SC)	A+	Stable
Anne Arundel Health System (MD)	A-	Stable
Ascension Health Alliance (MO)	AA+	Stable
Aurora Health Care, Inc. (WI)	A	Stable
Banner Health System (AZ)	AA-	Stable
Baptist Health Care (FL)	A-	Stable
Baptist Healthcare System (KY)	A+	Negative
Barnabas Health (NJ)	A-	Stable
BayCare Health System Inc. (FL)	AA	Stable
Bayhealth Medical Center, Inc. (DE)	AA-	Stable
Baystate Medical Center (MA)	A+	Stable
Beacon Health System, Inc. (IN)	AA-	Stable
Beloit Health System (WI)	A-	Stable
Berkshire Health System and Affiliates (MA)	A-	Stable
Blanchard Valley Health Association (OH)	A	Positive
Bon Secours Health Care System (MD)	A	Stable
Boone Hospital Center (MO)	A	Negative
Brooks Health System (FL)	A-	Stable
BRRH Corporation and Affiliates (FL)	BBB+	Stable
Bryan Medical Center (NE)	AA-	Stable
Butler Health System (PA)	A-	Stable
Calvert Memorial Hospital (MD)	A	Stable
Cape Cod Healthcare, Inc. and Affiliates (MA)	A-	Stable
Care New England (RI)	BBB-	Negative
Carson Tahoe Healthcare (NV)	BBB+	Stable
Cass Medical Center (MO)	BBB	Stable
Catholic Health Initiatives (CO)	BBB+	Negative
Catholic Health Services of Long Island (NY)	BBB+	Stable
Catholic Health System, Inc. and Subsidiaries (NY)	BBB+	Stable
Cedars Sinai Medical Center (CA)	AA-	Stable
Centegra Health System and Affiliates (IL)	BBB	Stable
Centracare Health System (MN)	A+	Stable
Central Washington Hospital (WA)	BBB+	Stable
Columbus Regional Healthcare System (GA)	BB+	Stable
Community Foundation of Northwest Indiana (IN)	A+	Stable
Community Hospital of the Monterey Peninsula (CA)	AA-	Stable
Concord Hospital and Subsidiaries (NH)	A+	Stable
Cone Health (NC)	AA	Stable
Cottage Health System Obligated Group (CA)	AA-	Stable
Covenant Health (MA)	A-	Negative
Covenant Health (TN)	A	Stable
CoxHealth (MO)	A	Stable
Cullman Regional Medical Center (AL)	BB+	Positive
Dartmouth-Hitchcock Obligated Group (NH)	A	Negative
Deaconess Health System (IN)	AA-	Stable
DeKalb Medical Center, Inc. (GA)	BBB-	Stable
Denver Health & Hospital Authority (CO)	BBB+	Stable
Dignity Health (CA)	A	Stable
Doctors Community Hospital (MD)	BB+	Stable

Note: Medians exclude specialty and critical access hospitals.

Hospital Ratings (continued)

(As of July 15, 2016)

Name	Long-Term Rating	Rating Outlook/Rating Watch
Duke University Health System (NC)	AA	Stable
East Texas Medical Center (TX)	BBB-	Negative
Ector County Hospital District (TX)	A-	RWE
Edward Hospital (IL)	A+	Stable
Einstein Healthcare Network (PA)	BBB	Stable
Eisenhower Medical Center (CA)	BBB	Stable
Elmhurst Memorial Healthcare and Subsidiaries (IL)	BBB	Positive
Erlanger Health System (TN)	BBB+	Stable
Essentia Health (MN)	A	Stable
FirstHealth of the Carolinas, Inc. (NC)	AA	Stable
Floyd Healthcare Management, Inc. (GA)	BBB+	RWE
Forrest County General Hospital (MS)	A	Stable
Franciscan Alliance, Inc. (IN)	AA	Stable
Frederick Memorial Hospital (MD)	BBB+	Stable
Froedtert and Community Health (WI)	AA-	Stable
Good Shepherd Rehabilitation Network and Controlled Entities (PA)	A	Stable
Great Plains Regional Medical Center (OK)	BB	RWN
Greater Fairbanks Community Hospital Foundation, Inc. (The) (AK)	A	Stable
Greenville Health System (SC)	AA-	Stable
Greenwich Hospital (CT)	AA-	Stable
Guadalupe Regional Medical Center (TX)	BB	Stable
Gundersen Lutheran (WI)	A+	Positive
Guthrie Health (PA)	A+	Positive
Gwinnett Health System, Inc. and Affiliates (GA)	A+	Stable
Hackensack University Medical Center (NJ)	A-	Stable
Halifax Community Health System (FL)	BBB+	RWE
Halifax Regional Medical Center (NC)	BB+	Positive
Harris County Hospital District (TX)	AA	Stable
Hartford HealthCare (CT)	A	Stable
Hawai'i Pacific Health (HI)	A+	Stable
HealthEast and Controlled Affiliates (MN)	BB+	Stable
Heartland Health (MO)	A+	Negative
Heritage Valley Health System (PA)	A+	Stable
Holy Redeemer Health System (PA)	BBB	Stable
Hospital Sisters Services Inc. (IL)	AA-	Stable
Houston County Health Care Authority (AL)	BBB+	Stable
Houston Healthcare, Inc. (GA)	A+	Stable
Hunterdon Medical Center (NJ)	A	Stable
Hurley Medical Center (MI)	BBB-	Stable
Indiana University Health (IN)	AA	Stable
Inspira Health Network (NJ)	A	Stable
Jackson County Schneck Memorial Hospital (IN)	A+	Stable
Jennie Stuart Medical Center (KY)	BBB-	Negative
John Fitzgibbon Memorial Hospital (MO)	BBB-	Stable
Johns Hopkins Health System (MD)	AA-	Stable
Jupiter Medical Center (FL)	BBB+	Stable
Karnes County Hospital District (dba Otto Kaiser Memorial Hospital) (TX)	BBB	RWE
King's Daughters' Hospital and Health Services (IN)	BBB+	Stable
King's Daughters' Medical Center (KY)	A-	Negative
Lafayette General Health System, Inc. (LA)	A-	Stable
Lahey Clinic Medical Center (MA)	A+	Stable
Lake Hospital System (OH)	A-	Stable
Lakeland Hospitals at Niles and St Joseph, Inc. (MI)	AA-	Stable
Lawrence & Memorial Hospital (CT)	A-	Negative
Lawrence General Hospital (MA)	BBB-	Negative

RWE – Rating Watch Evolving. RWN – Rating Watch Negative. Note: Medians exclude specialty and critical access hospitals.

Hospital Ratings (continued)

(As of July 15, 2016)

Name	Long-Term Rating	Rating Outlook/Rating Watch
Lexington County Health Services District, Inc. and Subsidiaries (SC)	A+	Stable
Loma Linda University Medical Center (CA)	BB+	Stable
Lowell General Hospital (MA)	BBB+	Stable
Main Line Health System, Inc. (PA)	AA	Stable
MaineGeneral Health (ME)	BBB-	Negative
Major Hospital (IN)	BBB+	RWE
Marietta Area Health Care Inc. dba Memorial Health System (OH)	BB	Stable
Marshall Medical (CA)	BB+	Positive
Mary Washington Healthcare (VA)	BBB+	Stable
McLaren Health Care Corporation (MI)	AA-	Stable
McLeod Regional Medical Center (SC)	AA-	Positive
MedStar Health, Inc. (MD)	A	Stable
Memorial Health Services (CA)	AA-	Stable
Memorial Hospital at Gulfport (MS)	BBB	RWE
Mercy Health (OH)	AA-	Negative
Mercy Regional Health Center, Inc. (KS)	A+	Stable
Meridian Health System, Inc. and Affiliates (NJ)	A+	Stable
Meritus Health (MD)	BBB	Stable
Methodist Hospitals, Inc. (The) (IN)	BBB	Stable
MetroHealth System (The) (OH)	A-	Stable
Mission Health System, Inc. (NC)	AA-	Stable
Mississippi Baptist Health Systems, Inc. and Subsidiaries (MS)	BBB	Negative
Monongalia Health System, Inc. (WV)	A-	Stable
Monroe Clinic (The) (WI)	A-	Stable
Mount Nittany Medical Center (PA)	A	Stable
Mount Sinai Hospital (NY)	A	Stable
Mount Sinai Medical Center of Greater Miami, Inc. (FL)	BBB+	Stable
Mountain States Health Alliance (TN)	BBB+	RWE
MultiCare Health System (WA)	AA-	Stable
Munson Healthcare Obligated Group (MI)	AA-	Stable
Nanticoke Health Services Obligated Group (DE)	BBB-	Stable
National Jewish Medical & Research Center (CO)	BB+	Positive
NCH Healthcare System (FL)	A+	Stable
NCMC, Inc. (CO)	A+	Stable
Nebraska Methodist Health System, Inc. (NE)	A-	Stable
New York and Presbyterian Hospital (NY)	AA	Stable
New York Methodist Hospital (NY)	A-	Stable
New York University Hospitals Center (NY)	A-	Stable
Norman Regional Hospital Authority (OK)	BBB-	Positive
North Mississippi Health Services (MS)	AA	Stable
North Shore-Long Island Jewish Health System, Inc. (NY)	A	Stable
Northeast Georgia Health System (GA)	A	RWE
Norton Healthcare, Inc. and Affiliates (KY)	A	Stable
Novant Health, Inc. (NC)	AA-	Stable
Ochsner Clinic Foundation (LA)	A-	Stable
OhioHealth Corporation (OH)	AA	Stable
Olmsted Medical Center (MN)	A-	Stable
Orange Regional Medical Center (NY)	BB+	Stable
Oregon Health & Science University (OR)	AA-	Stable
Orlando Regional Healthcare System (FL)	A	Stable
OSF Healthcare System (IL)	A	Stable
Owensboro Medical Health System (KY)	BBB+	Negative
Palisades Medical Center (NJ)	BBB+	Stable
Palmetto Health (SC)	BBB+	Stable

RWE – Rating Watch Evolving. Note: Medians exclude specialty and critical access hospitals.

Hospital Ratings (continued)

(As of July 15, 2016)

Name	Long-Term Rating	Rating Outlook/Rating Watch
Palos Community Hospital (IL)	AA-	Stable
Parrish Medical Center (FL)	BBB	RWE
Partners Healthcare System, Inc. and Affiliates (MA)	AA	Stable
PeaceHealth (WA)	A+	Stable
Peterson Regional Medical Center (TX)	BBB+	Stable
Pocono Medical Center (PA)	A	Stable
Presbyterian Healthcare Services (NM)	AA	Stable
Presence Health Network (IL)	BBB	Negative
Princeton HealthCare System Holding, Inc. (NJ)	BBB	Stable
Providence Health and Services (WA)	AA-	Stable
Reading Hospital and Controlled Entities (PA)	A+	Stable
Rehabilitation Institute of Chicago (IL)	A-	Stable
Rehoboth McKinley Christian Hospital (NM)	B	Negative
Reid Hospital and Health Care Services (IN)	A	Positive
Rex Hospital (NC)	AA-	Negative
Rush University Medical Center Obligated Group (IL)	A+	Positive
Saint Francis Healthcare System (MO)	AA-	Stable
Salem Hospital (OR)	A+	Stable
San Juan Regional Medical Center, Inc. (NM)	A-	Positive
Sarasota County Public Hospital Board and Affiliates (FL)	AA-	RWE
Scottsdale Healthcare Corporation (AZ)	A	Stable
Scripps Health (CA)	AA	Stable
Seattle Cancer Care Alliance (WA)	A+	Stable
Shands Jacksonville HealthCare, Inc. (FL)	BBB	Stable
Sierra View Local Health Care District (CA)	A	Stable
Silver Cross Health System (IL)	BBB+	Stable
Sisters of Charity of Leavenworth Health Services Corporation (CO)	AA-	Stable
Sky Lakes Medical Center (OR)	A-	Positive
South Lake Hospital, Inc. (FL)	A-	Stable
South Nassau Communities Hospital (NY)	A-	Stable
South Shore Hospital (MA)	BBB+	Stable
Southeast Missouri Hospital Association (MO)	BB+	Stable
Southeastern Regional Medical Center (NC)	A	Stable
Southern Illinois Healthcare (IL)	A+	Stable
Spartanburg Regional Health Services District, Inc. (SC)	A	Stable
SSM Health Care (MO)	AA-	Stable
St. Anthony's Medical Center (MO)	A	Stable
St. Clair Hospital (PA)	AA-	Stable
St. Elizabeth Medical Center (KY)	AA	Stable
St. Francis Regional Medical Center (MN)	A	Stable
St. Joseph Health System (CA)	AA-	Stable
St. Joseph's County/Candler Health System, Inc. (GA)	A-	Stable
St. Luke's Episcopal Presbyterian Hospitals (MO)	A+	Stable
St. Tammany Parish Hospital Service District No. 1 (LA)	A	Stable
Stamford Health System (CT)	A	Stable
Stanford Hospital and Clinics (CA)	AA	Stable
Summa Health System and Subsidiaries (OH)	A-	Stable
Summit Health (PA)	A+	Stable
Susquehanna Health System (PA)	A-	Stable
Sutter Health (CA)	AA-	Stable
Swedish Covenant Hospital (IL)	BBB+	Stable
Tampa General Hospital (FL)	A	Stable
Temple University Health System (PA)	BB+	Positive
ThedaCare, Inc. (WI)	AA-	Stable

RWE – Rating Watch Evolving. Note: Medians exclude specialty and critical access hospitals.

Hospital Ratings (continued)

(As of July 15, 2016)

Name	Long-Term Rating	Rating Outlook/Rating Watch
Trinity Health Credit Group (MI)	AA	Negative
Trinity-Mother Frances Health System (TX)	BBB+	Positive
Tufts Medical Center (MA)	BBB	Stable
Tulare Local Health Care District (CA)	BB-	RWP
UMass Memorial Health Care, Inc. (MA)	A-	Stable
UnityPoint Health (IA)	AA-	Stable
University Health System, Inc. (TN)	BBB+	Stable
University of Chicago Medical Center (IL)	AA-	Stable
University of Colorado Health, Inc. (CO)	AA-	Stable
University of Kansas Hospital (KS)	A+	Stable
University of Maryland Medical System (MD)	A	Stable
University of Vermont Medical Center Inc. (VT)	A-	Stable
UPMC Health System (PA)	AA-	Stable
Valley Medical Center (WA)	BBB+	RWE
Virginia Hospital Center Arlington Health System (VA)	AA-	Stable
Virtua Health (NJ)	AA-	Stable
WakeMed Health & Hospitals (NC)	A+	Stable
Washington Hospital (PA)	A-	Stable
Wellmont Health System (TN)	BBB+	RWE
Wellspan Health (PA)	AA-	Stable
Wentworth-Douglass Hospital (NH)	A	Positive
Western Connecticut Health Network (CT)	A	Stable
Winchester Hospital (MA)	A-	Stable
Winthrop University Hospital (NY)	BBB+	Stable
Wise Regional Health System (TX)	BB+	Stable
Yale New Haven Health Obligated Group (CT)	AA-	Stable
Yavapai Community Hospital (AZ)	BBB+	Positive

RWP – Rating Watch Positive. RWE – Rating Watch Evolving. Note: Medians exclude specialty and critical access hospitals.

Definition of Ratios

Liquidity

To obtain unrestricted liquidity, unrestricted cash and investments are added to a portion of assets limited as to use. Within assets limited as to use, Fitch includes board-designated assets set aside for capital improvements or investment as unrestricted because these funds are limited at the board of trustees' discretion and can be used for operating purposes.

Daily cash operating expenses and daily net patient revenue are used in several of the ratios defined below. Daily cash operating expenses are defined as total operating expenses less noncash expenses, such as depreciation expense, amortization expense and provision for uncollectible accounts (bad debt expense), divided by 365 days. Daily net patient revenue is defined as net patient revenue divided by 365 days.

Days Cash on Hand: Unrestricted cash and investments divided by daily cash operating expenses.

Days in Accounts Receivable: Net patient accounts receivable divided by daily net patient revenue.

Cushion Ratio (x): Unrestricted cash and investments divided by MADS.

Days in Current Liabilities: Total current liabilities divided by daily cash operating expenses.

Cash to Debt (%): Unrestricted cash and investments divided by total debt.

Profitability

Operating Margin (%): Total operating revenue minus total operating expenses, divided by total operating revenue.

Operating EBITDA Margin (%): Income from operations before interest, taxes, depreciation and amortization, divided by total operating revenue.

Excess Margin (%): Total operating revenue minus total operating expenses plus non-operating revenue, divided by total operating revenue plus non-operating revenue.

EBITDA Margin (%): EBITDA, divided by total operating revenue plus non-operating revenue.

Investment Income as % of Excess Net Income: Investment income, divided by total operating revenue minus total operating expenses plus non-operating revenue.

Operational

Personnel Costs as % of Total Operating Revenue: Salaries, wages, benefits and professional fees divided by total operating revenue.

Bad Debt as % of Patient Revenue: Bad debt divided by net patient revenue plus bad debt.

Capital Structure and Cash Flow

EBITDA Debt Service Coverage (x): EBITDA divided by MADS.

Operating EBITDA Debt Service Coverage (x): Operating EBITDA divided by MADS.

MADS as % of Revenue: MADS divided by the sum of total operating revenue.

Debt to EBITDA (x): Total debt divided by EBITDA.

Debt to Capitalization (%): Total debt divided by total debt plus unrestricted net assets.

Capital Expenditures as % of Depreciation Expense: Net acquisitions of property, plant and equipment divided by depreciation expense.

Average Age of Plant (Years): Accumulated depreciation divided by depreciation expense.

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RatingsDirect®

U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios -- 2015 vs. 2014

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Similar to the overall medians for stand-alone hospitals and health care systems combined (see "U.S. Not-For-Profit Acute Health Care Ratios Are Calm On The Surface But Turbulent Underneath," published Sept. 21, 2016 on RatingsDirect), we saw stronger operating margins for stand-alone hospitals in 2015 at each rating category, offset by consistently softer non-operating revenue compared to 2014 (see table 1). Overall, maximum annual debt service coverage remained relatively stable with some minor variations by category. Balance sheet metrics were also fairly stable although days' cash on hand declined slightly in all categories except the 'AA' category which saw a slight increase. Unrestricted reserves compared to debt were essentially flat across all categories. Debt levels were stable year to year as measured by the debt burden and debt as a percent of capitalization. The defined benefit pension plan funded status dropped in every rating category with adoption of the new mortality tables and declines in discount rate and we expect that pension shortfalls will continue to contribute to expense pressure and require significant annual funding. However many providers have or are in the process of exiting defined benefit plans and moving to more predictable defined contribution models.

The rating distribution for stand-alone hospitals has remained fairly stable over time although the four-year view (see chart 1) does show some incremental strengthening with a higher percent of ratings in the top two categories ('AA' and 'A'). S&P Global Ratings believes this moderate improvement reflects benefits of Medicaid expansion, management attention to operational efficiencies, implementation of our revised stand-alone criteria, and the benefits of larger size and scale.

In line with our stable sector outlook, the vast majority of the stand-alone ratings carry stable outlooks (see chart 2). In addition, over the past several years the number of negative outlooks has steadily declined to the point that in 2015 and 2016 the percent of positive and negative outlooks are almost identical. S&P Global Ratings has outstanding ratings on 320 stand-alone hospitals of which 294 (92%) are included in the median ratios.

Due to the lack of geographic diversity for stand-alone hospitals, these providers are generally more vulnerable to conditions in their single markets, such as immediate competition for patients and physicians, local economic swings, and demographic shifts. For sole community hospitals, competition is often less of an immediate threat, but broader industry trends continue to pressure volume at these facilities. Given these and other challenges facing many stand-alone providers, the financial profile of a stand-alone hospital generally needs to be stronger than that of a health system with a similar rating.

Ratios at the individual rating level are highlighted by generally solid revenue growth and improvement in the operating margin at every single rating level except 'BBB-' where the margin was flat (see table 2). Despite soft non-operating performance offsetting improved operations, maximum annual debt service coverage in 2015 remained fairly comparable to 2014 levels although results were mixed among various rating levels. Unrestricted reserves as measured by days' cash on hand declined at most rating levels, except for minor increases in the 'BBB' and 'A-' levels reflecting 2015's weak investment markets, pension funding requirements, and continued strategic capital needs. In addition, debt as a percent of capitalization trends were somewhat mixed at specific rating levels, although the debt

burden was generally flat. This suggests that the volatility in debt as a percent of capitalization was driven more by changes in unrestricted net assets--a combination of realized and unrealized losses on investments as well as losses relative to defined benefit pension plans--than by a true shift in debt profiles. Capital spending ratios follow prior-year trends with speculative grade credits typically spending less than depreciation expense annually for capital which results in a higher average age of plant. This reflects much tighter controls on capital spending at financially weaker organizations as these ratios generally improve as you move up the rating spectrum.

Ratio Analysis

While we view ratio analysis as an important tool in our assessment of the credit quality of not-for-profit hospitals and health care systems, it is only one of several factors that we take into consideration. Our analysis of the enterprise profile is as important. However, median ratios offer a snapshot of the financial position of our rated hospitals and help in the comparison of credits across rating categories. In addition, we believe tracking median ratios over time allows for a clearer understanding of industrywide trends and provides a tool to better assess the sector's future credit quality. Because of the intertwining of mission and operations among all members of an organization, the financial statements we generally use for the medians and our analyses are the systemwide results, which include results for obligated and nonobligated group members.

Chart 1

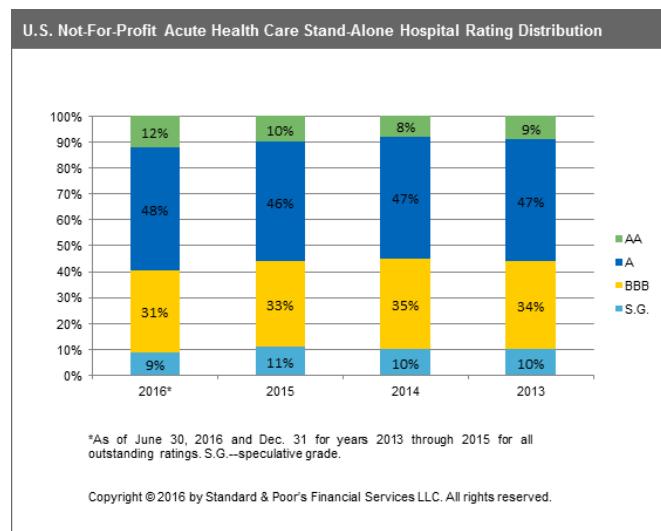


Chart 2

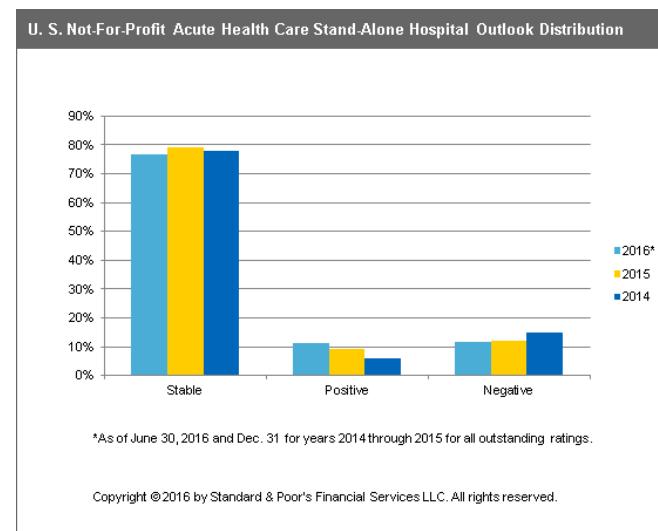


Table 1

U.S. Not-For-Profit Acute Stand-Alone Hospital Medians By Rating Category -- 2015 vs. 2014

Fiscal year-end	AA		A		BBB		Speculative Grade	
	2015	2014	2015	2014	2015	2014	2015	2014
Sample size	33	34	137	155	97	112	27	35
Statement of operations								
Net patient revenue (NPR; \$000)	878,082	873,336	429,850	408,424	205,988	174,975	101,765	100,694
Salaries & benefits/NPR (%)	56.0	56.3	54.5	55.4	54.8	56.3	51.1	54.9

Table 1**U.S. Not-For-Profit Acute Stand-Alone Hospital Medians By Rating Category -- 2015 vs. 2014 (cont.)**

Fiscal year-end	AA		A		BBB		Speculative Grade	
	2015	2014	2015	2014	2015	2014	2015	2014
Maximum annual debt service coverage (x)	6.7	6.5	4.5	4.8	3.3	2.9	1.7	1.8
Operating lease-adjusted coverage (x)*	5.3	5.4	3.8	3.7	2.8	2.5	1.6	1.7
Debt burden (%)	2.2	2.4	2.8	2.8	3.4	3.5	4.0	4.2
EBIDA (\$000)	147,085	149,317	58,576	51,238	26,970	20,653	10,499	8,407
Nonoperating revenue/total revenue (%)	2.9	3.9	2.0	2.8	1.5	1.7	1.1	1.4
EBIDA margin (%)	15.7	15.1	13.1	12.9	10.7	10.8	8.4	7.7
Operating EBIDA margin (%)	12.4	11.9	10.8	10.5	9.3	8.6	7.8	5.9
Operating margin (%)	5.8	5.2	3.6	3.3	2.4	1.3	(0.7)	(3.9)
Excess margin (%)	9.4	8.7	5.8	6.1	4.1	3.1	0.5	(0.8)
Capital expenditures/depr. & amort. exp. (%)	132.5	125.2	110.8	109.5	95.6	90.2	60.7	52.2
Balance sheet								
Average age of plant (years)	10.6	10.4	10.6	10.7	11.9	11.9	13.9	11.6
Cushion ratio (x)	38.2	36.5	22.4	22.1	12.5	12.0	5.3	5.0
Days' cash on hand	384.2	378.5	248.6	261.6	158.5	160.3	85.9	86.8
Days in accounts receivable	48.5	50.9	49.3	49.2	46.5	48.0	52.2	53.3
Cash flow/total liabilities (%)	24.6	26.4	19.6	19.1	14.7	14.2	7.6	7.3
Unrestricted reserves (\$000)	791,883	796,202	282,197	260,998	91,752	80,397	21,537	25,766
Unrestricted reserves/long-term debt (%)	283.5	296.2	189.9	182.0	115.5	112.2	59.4	58.3
Unrestricted reserves/contingent liabilities (%)*	527.4	597.4	485.7	499.0	279.1	396.3	283.0	193.5
Contingent liabilities/long-term debt (%)*	40.3	44.3	35.7	31.1	44.4	28.5	43.5	27.5
Long-term debt/capitalization (%)	21.9	21.4	29.1	29.4	36.0	34.6	48.1	48.5
DB pension funded status (%)*	78.8	84.7	79.1	82.2	73.5	79.0	63.6	73.2
Pension-adjusted long-term debt/capitalization (%)*	23.5	24.1	30.8	31.2	40.9	37.3	52.4	51.5

*These five ratios are only for organizations that have defined-benefit (DB) pension plans, operating leases, or contingent liabilities.

Table 2A**U.S. Not-For-Profit Acute Stand-Alone Hospital Medians By Rating Level -- 2015 vs. 2014**

Fiscal year-end	AA+/AA**		AA-		A+		A		A-	
	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014
Sample size	11	12	22	22	46	50	41	50	50	55
Statement of operations										
Net patient revenue (NPR; \$000)	1,352,895	1,389,987	865,171	768,944	540,173	483,641	394,224	339,869	355,192	316,518
Salaries & benefits/NPR (%)	58.7	57.5	54.6	55.3	53.1	53.6	55.5	55.7	55.1	55.4
Maximum annual debt service coverage (x)	7.1	7.4	6.4	5.7	6.0	5.7	4.6	4.8	3.8	3.8

Table 2A**U.S. Not-For-Profit Acute Stand-Alone Hospital Medians By Rating Level -- 2015 vs. 2014 (cont.)**

Fiscal year-end	AA+/AA**		AA-		A+		A		A-	
	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014
Operating lease-adjusted coverage (x)*	5.6	6.6	4.7	4.7	4.4	4.7	3.4	3.7	3.1	3.2
Debt burden (%)	2.1	2.2	2.3	2.7	2.6	2.6	2.8	2.7	3.0	3.1
EBIDA (\$000)	318,211	329,062	129,972	123,699	79,303	81,798	53,982	47,534	41,652	40,411
Nonoperating revenue/total revenue (%)	2.5	4.9	2.9	3.5	2.8	3.5	2.1	2.9	1.7	2.1
EBIDA margin (%)	15.8	16.1	15.3	14.7	15.0	15.4	12.6	12.9	11.5	11.5
Operating EBIDA margin (%)	12.4	13.4	12.3	10.9	12.6	12.0	10.6	9.9	10.0	9.8
Operating margin (%)	7.1	6.0	5.8	4.6	5.4	4.3	3.4	2.5	3.3	3.0
Excess margin (%)	10.0	9.4	8.8	7.9	8.2	7.8	5.2	5.8	5.0	5.1
Capital expenditures/depr. & amort. exp. (%)	137.2	134.3	129.8	111.1	109.9	105.9	103.7	104.7	121.2	119.0
Balance sheet										
Average age of plant (years)	11.4	9.5	10.5	10.6	10.3	10.1	10.1	10.9	10.9	10.8
Cushion ratio (x)	42.8	40.8	37.9	32.0	28.7	29.1	22.2	22.8	18.0	18.5
Days' cash on hand	390.4	401.8	350.6	358.5	294.9	316.0	248.1	273.1	209.8	202.6
Days in accounts receivable	48.2	51.8	48.6	50.0	48.0	49.6	47.2	50.2	49.7	47.2
Cash flow/total liabilities (%)	27.5	29.0	21.3	23.4	27.0	24.4	18.5	20.1	16.5	16.1
Unrestricted reserves (\$000)	1,468,247	1,566,248	662,366	694,797	440,466	439,565	252,862	251,776	209,948	189,915
Unrestricted reserves/long-term debt (%)	312.1	331.2	268.2	260.1	235.6	221.7	190.3	187.2	146.4	149.9
Unrestricted reserves/contingent liabilities (%)*	672.1	608.6	516.1	539.1	620.8	605.5	487.7	625.4	410.1	389.3
Contingent liabilities/long-term debt (%)*	44.0	55.1	38.0	41.5	43.5	33.8	28.3	28.0	35.2	29.3
Long-term debt/capitalization (%)	21.0	19.4	23.6	23.4	24.0	24.5	29.1	28.8	36.1	32.6
DB pension funded status (%)*	87.0	87.3	74.5	78.4	79.0	84.6	80.3	80.9	76.8	81.9
Pension-adjusted long-term debt/capitalization (%)*	22.1	20.1	28.6	26.2	27.2	27.3	32.6	31.3	36.6	36.1

*These five ratios are only for organizations that have defined-benefit (DB) pension plans, operating leases, or contingent liabilities. **Includes nine 'AA-' and two 'AA+' rated hospitals

Table 2B**U.S. Not-For-Profit Acute Stand-Alone Hospital Medians By Rating Level -- 2015 vs. 2014**

Fiscal year-end	BBB+		BBB		BBB-		Speculative Grade	
	2015	2014	2015	2014	2015	2014	2015	2014
Sample size	31	39	39	35	27	38	27	35
Statement of operations								
Net patient revenue (NPR; \$000)	276,346	214,356	264,433	181,454	123,203	164,909	101,765	100,694
Salaries & benefits/NPR (%)	53.0	57.6	55.1	57.2	55.3	54.1	51.1	54.9

Table 2B**U.S. Not-For-Profit Acute Stand-Alone Hospital Medians By Rating Level -- 2015 vs. 2014 (cont.)**

Fiscal year-end	BBB+		BBB		BBB-		Speculative Grade	
	2015	2014	2015	2014	2015	2014	2015	2014
Maximum annual debt service coverage (x)	3.5	3.3	3.3	2.8	3.2	2.7	1.7	1.8
Operating lease-adjusted coverage (x)*	3.0	2.8	2.7	2.4	2.5	2.4	1.6	1.7
Debt burden (%)	3.4	3.4	3.3	3.5	3.4	3.6	4.0	4.2
EBIDA (\$000)	31,615	24,117	30,220	20,543	15,524	17,572	10,499	8,407
Nonoperating revenue/total revenue (%)	1.6	2.5	1.7	1.7	1.2	1.2	1.1	1.4
EBIDA margin (%)	12.2	11.6	10.5	10.8	8.5	10.2	8.4	7.7
Operating EBIDA margin (%)	10.4	8.7	9.6	8.5	7.5	8.6	7.8	5.9
Operating margin (%)	2.8	1.8	3.0	0.4	1.5	1.5	(0.7)	(3.9)
Excess margin (%)	5.0	4.0	3.9	2.5	2.9	2.8	0.5	(0.8)
Capital expenditures/depr. & amort. exp. (%)	98.5	106.1	91.5	74.8	85.1	90.9	60.7	52.2
Balance sheet								
Average age of plant (years)	11.2	12.2	13.1	11.6	11.6	12.2	13.9	11.6
Cushion ratio (x)	13.8	14.5	12.6	11.2	10.4	10.0	5.3	5.0
Days' cash on hand	202.6	207.9	164.4	150.9	132.5	141.7	85.9	86.8
Days in accounts receivable	43.5	46.1	46.5	47.1	51.0	50.1	52.2	53.3
Cash flow/total liabilities (%)	17.0	14.9	13.8	12.8	14.0	14.7	7.6	7.3
Unrestricted reserves (\$000)	119,482	107,562	99,532	90,970	54,500	62,013	21,537	25,766
Unrestricted reserves/long-term debt (%)	155.8	157.4	132.0	101.1	102.3	102.2	59.4	58.3
Unrestricted reserves/contingent liabilities (%)*	402.2	290.3	198.7	439.0	270.2	306.4	283.0	193.5
Contingent liabilities/long-term debt (%)*	44.4	38.2	44.9	21.3	40.9	25.6	43.5	27.5
Long-term debt/capitalization (%)	35.0	31.8	37.5	35.5	40.9	39.4	48.1	48.5
DB pension funded status (%)*	70.1	83.2	75.6	79.3	60.2	68.6	63.6	73.2
Pension-adjusted long-term debt/capitalization (%)*	36.0	34.6	42.4	38.7	42.7	40.8	52.4	51.5

*These five ratios are only for organizations that have defined-benefit (DB) pension plans, operating leases, or contingent liabilities.

Related Research

- U.S. Not-For-Profit Health Care System Median Financial Ratios -- 2015 vs. 2014, Sept. 21, 2016
- U.S. Not-For-Profit Health Care Small Stand-Alone Hospital Median Financial Ratios -- 2015, Sept. 21, 2016
- U.S. Not-For-Profit Health Care Children's Hospital Median Financial Ratios -- 2015, Sept. 21, 2016
- U.S. Not-For-Profit Acute Health Care Speculative Grade Median Financial Ratios -- 2015, Sept. 21, 2016

Glossary of our ratios

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011

Monthly rating changes

- U.S. Not-For-Profit Health Care Rating Actions, December 2015, Jan. 27, 2016
- U.S. Not-For-Profit Health Care Rating Actions, November 2015, Dec. 15, 2015
- U.S. Not-For-Profit Health Care Rating Actions, October 2015, Nov. 16, 2015
- U.S. Not-For-Profit Health Care Rating Actions, September 2015, Oct. 21, 2015
- U.S. Not-For-Profit Health Care Rating Actions, August 2015, Sept. 23, 2015
- U.S. Not-For-Profit Health Care Rating Actions, July 2015, Aug. 19, 2015
- U.S. Not-For-Profit Health Care Rating Actions, June 2015, July 15, 2016
- U.S. Not-For-Profit Health Care Rating Actions, May 2015, June 25, 2015
- U.S. Not-For-Profit Health Care Rating Actions, April 2015, May 20, 2015
- U.S. Not-For-Profit Health Care Rating Actions, March 2015, April 17, 2015
- U.S. Not-For-Profit Health Care Rating Actions, February 2015, March 31, 2015
- U.S. Not-For-Profit Health Care Rating Actions, January 2015, Feb. 25, 2015

For a list of outstanding acute care stand-alone and health system ratings and outlooks please see:

- U.S. Not-For-Profit Acute Health Care Outstanding Ratings And Outlooks As Of June 30, 2016, Sept. 21, 2016

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INDIAN RIVER MEDICAL CENTER

GOVERNANCE COMMITTEE CHARTER

Indian River Medical Center improves the health and well-being of the people of the communities it serves. Indian River Medical Center is a widely-recognized leader in providing exceptional, evidence-based, patient-centered care.

Consistent with the Medical Center's Mission and Vision, the Board of Directors develops strategies for future improvements that will better achieve the Medical Center's overall goals of safe, high-quality care, financial sustainability, community services and ethical behavior.

This charter (the "Charter") sets forth the duties and responsibilities of the Governance Committee (the "Committee") delegated to it by the Board of Directors (the "Board") of Indian River Memorial Hospital, Inc. d/b/a Indian River Medical Center and its group of companies (the "Medical Center").

I. PURPOSE

The Committee's purpose is to provide for the Board's effectiveness and continuing development as set forth in this Charter.

II. DUTIES AND RESPONSIBILITIES

The Governance Committee:

- Recommends to the Board policies and processes designed to provide for effective and efficient governance, including but not limited to policies for:
 - Evaluation of the Board and the Chairperson.
 - Election and reelection of Board members.
 - Board orientation and education.
 - Succession planning for the Board chair, other Board leaders and the President/CEO.
 - Reviews and approves the Succession Plan Policy regarding Vice President Vacancies.
- Reviews and recommends a position description detailing responsibilities of and expectations for Board Officers and Directors.
- Recommends nominees for election and reelection to the Board. To facilitate this responsibility, the Committee:

- Develops and recommends to the Board a statement of the competencies and personal attributes currently needed on the Board, to be used as a guideline for recruitment and election of Board members.
 - Conducts a “gap analysis” to identify succession planning/recruitment needs.
 - Develops and regularly updates a list of potential Board members regardless of whether a current vacancy exists.
 - Oversees a process for vetting the fitness of prospective nominees.
 - Develops and oversees a plan for enhancing Board diversity.
 - Evaluates the performance of individual Board members eligible for reelection.
- Conducts a succession planning process for the Board Chairperson and other Board leaders.
 - Nominates Board officers for election by the full Board.
 - Reviews the Medical Center’s corporate Bylaws every one to two years and recommends any needed changes to the full Board.
 - Advises management regarding plans for Board education, including new member orientation, education of Board members, and an annual Board retreat.
 - Oversees the Board’s self-assessment and improvement process every one or two years.

III. COMPOSITION AND CONDUCT

The Committee’s membership, the Chairperson, the call and conduct of the Committee meetings, the preparation of Committee minutes and the Committee’s other activities shall be appointed, conducted and accomplished in accordance with applicable provisions of the Medical Center’s Bylaws and applicable corporate governance principles adopted by the Medical Center’s Governance Committee.

The Committee consists of at least three (3) members of the Board in addition to the Chairman, the President and one (1) Trustee appointed by Indian River Hospital District.

IV. REPORTS

The Committee receives and reviews the following reports:

- Competency matrix. Profile or matrix of the Board’s current make-up compared to its list of needed competencies, plus an analysis showing areas to emphasize in recruitment of new members.
- Backgrounds of prospective Board members.

- Annual Board education plan.
- Participation summary. Annual review of average attendance, and each Director's attendance, at Board meetings, committee meetings, education sessions, and (if possible) community events.
- Board self-assessment. Report of the full Board's self-evaluation survey (every one or two years).
- Chief Legal counsel's report. Written report or briefing from the counsel regarding current legal and regulatory issues affecting governance, plus analysis of whether any changes are needed in Board bylaws or policies.

V. ANNUAL COMMITTEE GOALS

The Governance Committee will establish annual goals specifying its principal work focus areas for the coming year. Typical examples might include:

- Developing a definition of and standards for independent directors.
- Reviewing and revising the conflict of interest policy.
- Conducting a comprehensive evaluation of the responsibilities and structure of subsidiary boards and making recommendations to the full Board for needed changes.
- Developing a mentoring program for new Board members.
- Developing a plan to increase the ethnic and gender diversity of the Board.

VI. PERFORMANCE EVALUATION

The Committee prepares and reviews with the Board an annual performance evaluation of the Committee. Such evaluation compares the performance of the Committee with the requirements of this Charter. The performance evaluation shall recommend to the Board any amendments to this Charter deemed necessary or desirable by the Committee. The performance evaluation is conducted in such manner as the Committee deems appropriate. The report to the Board may take the form of an oral report by the Chairperson or any other member of the Committee designated by the Committee to make the report.

VII. AMENDMENT

This Charter may not be amended except upon approval by the Board.

Approved by Governance Committee 5-14-13
Approved by Board of Directors 5-22-13

Approved by the Board of Directors
March 26, 2014

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Board and Committee Meeting Schedule 2017

January January 19, 2017

9:00 am New Board Member
Orientation
12:00 pm IRMC Board/Health
Systems/Health Services Joint
Annual Meeting

January 23, 2017

10:30 am Executive
Compensation Compliance
Subcommittee
12:00 pm Governance

January 24, 2017

11:00 am Audit Subcommittee
12:30 pm Finance Committee
2:00 pm Compliance

January 25, 2017

2:00 pm Strategic Planning
4:00 pm Joint Conf.
4:30 pm Patient Care

January 26, 2017

10:00 am Board

January 27, 2017

8:30 am Education for
Compliance Committee

Created 7.7.16
DRAFT Revised 11.30.16

Potential IRMC Board Transition Plan
Presented to Governance Committee in August 2015

Current = 17 Board Members

Proposed = 13 Board Members

Executive Summary

January 2016 (16 Directors)	11 Independent Directors • 8 Board Appointments • 3 District Appointments 3 Medical Staff Members 1 Foundation 1 Chief Executive Officer
January 2017 (15 Directors)	11 Independent Directors • 8 Board Appointments • 3 District Appointments 2 Medical Staff Members 1 Foundation Member 1 Chief Executive Officer
January 2018 (14 Directors)	10 Independent Directors • 7 Board Appointments • 3 District Appointments 2 Medical Staff Members 1 Foundation Member 1 Chief Executive Officer
January 2019 (14 Directors)	10 Independent Directors • 7 Board Appointments • 3 District Appointments 2 Medical Staff Members 1 Foundation Member 1 Chief Executive Officer
January 2020 (13 Directors)	9 Independent Directors • 7 Board Appointments • 2 District Appointments 2 Medical Staff Members 1 Foundation Member 1 Chief Executive Officer

Potential IRMC Board Transition Plan
Presented to Governance Committee in August 2015

Current = 17 Board Members

Proposed = 13 Board Members

Independent Directors

	Class	Recommendation
I.	Class of 2015	
	• District Appointment Eligible for Reappointment	Fill Seat
	• Board Appointee Eligible for Reappointment	Fill Seat
	• Board Appointee Eligible for Reappointment	Fill Seat
	• Board Appointee Eligible for Reappointment	Eliminate Seat
II.	Class of 2016	
	• District Appointment Eligible for Reappointment	Fill Seat
	• Board Appointee Eligible for Reappointment	Fill Seat
	• Board Appointee Eligible for Reappointment	Fill Seat
	• Board Appointee Eligible for Reappointment	Fill Seat
III.	Class of 2017	
	• District Appointment Eligible for Reappointment	Fill Seat
	• Board Appointee Eligible for Reappointment	Fill Seat
	• Board Appointee Eligible for Reappointment	Fill Seat
	• Board Appointee Not Eligible for Reappointment	Eliminate Seat
IV.	Class of 2018	
	• District Appointment Eligible for Reappointment	Fill Seat
	• Board Appointee Eligible for Reappointment	Fill Seat
	• Board Appointee Eligible for Reappointment	Fill Seat
V.	Class of 2019	
	• District Appointment Eligible for Reappointment	Eliminate
	• Board Appointee Eligible for Reappointment	Fill Seat
	• Board Appointee Eligible for Reappointment	Fill Seat
	• Board Appointee Eligible for Reappointment	Fill Seat
VI.	Medical Staff Members	
	• Continue Chief of Staff	
	• Continue Vice Chief of Staff	
	• Eliminate Medical Staff Representative in December 2016	
VII.	Exofficio Members	
	• Continue Foundation Chairman	
	• Continue Chief Executive Officer without vote	

**Potential IRMC Board Transition Plan
Presented to Governance Committee
December 12, 2016**

Current = 17 Board Members

Proposed = 13 Board Members

Executive Summary

January 2018
(16 Directors)

11 Independent Directors
• 8 Board Appointments
• 3 District Appointments
3 Medical Staff Members
1 Foundation Member
1 Chief Executive Officer

January 2019
(15 Directors)

11 Independent Directors
• 8 Board Appointments
• 3 District Appointments
2 Medical Staff Members
1 Foundation Member
1 Chief Executive Officer

January 2020
(14 Directors)

10 Independent Directors
• 7 Board Appointments
• 3 District Appointments
2 Medical Staff Members
1 Foundation Member
1 Chief Executive Officer

January 2021
(13 Directors)

9 Independent Directors
• 7 Board Appointments
• 2 District Appointments
2 Medical Staff Members
1 Foundation Member
1 Chief Executive Officer

Potential IRMC Board Transition Plan
Presented to Governance Committee
December 12, 2016

Current = 17 Board Members

Proposed = 13 Board Members

Independent Directors

	Class		Recommendation
I.	Class of 2018 - 2020		
	<ul style="list-style-type: none">• District Appointment Eligible for Reappointment• Board Appointee Eligible for Reappointment• Board Appointee Eligible for Reappointment• Board Appointee Eligible for Reappointment		<ul style="list-style-type: none">Fill SeatFill SeatFill SeatEliminate Seat
II.	Class of 2019 - 2021		
	<ul style="list-style-type: none">• District Appointment Eligible for Reappointment• Board Appointee Eligible for Reappointment• Board Appointee Eligible for Reappointment• Board Appointee Eligible for Reappointment		<ul style="list-style-type: none">Fill SeatFill SeatFill SeatFill Seat
III.	Class of 2020 - 2022		
	<ul style="list-style-type: none">• District Appointment Eligible for Reappointment• Board Appointee Eligible for Reappointment• Board Appointee Eligible for Reappointment• Board Appointee Not Eligible for Reappointment		<ul style="list-style-type: none">Fill SeatFill SeatFill SeatEliminate Seat
IV.	Class of 2021 - 2023		
	<ul style="list-style-type: none">• District Appointment Eligible for Reappointment• Board Appointee Eligible for Reappointment• Board Appointee Eligible for Reappointment• Board Appointee Not Eligible for Reappointment		<ul style="list-style-type: none">Eliminate SeatFill SeatFill SeatFill with District Appointment
V.	Medical Staff Members		
	<ul style="list-style-type: none">• Continue Chief of Staff• Continue Vice Chief of Staff• Eliminate Medical Staff Representative in December 2018		
VI.	Exofficio Members		
	<ul style="list-style-type: none">• Continue Foundation Chairman• Continue Chief Executive Officer without vote		

IRMC Board Education Plan 2017

- General/Compliance Education
 - 1. Jamie Olikoff – January 27, 2017
 - 2. Daniel Zismer, Ph. D. – March 2017
 - 3. Virginia Mason Follow up
 - 4. Medical Staff Credentials Process
 - 5. Patient Safety – Quality
 - 6. Patient Experience – University of Maryland