



Lower Keys Medical Center

HB 711 Evaluation Report

Final Report

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Prepared for Akerman LLP

Strictly Private and Confidential

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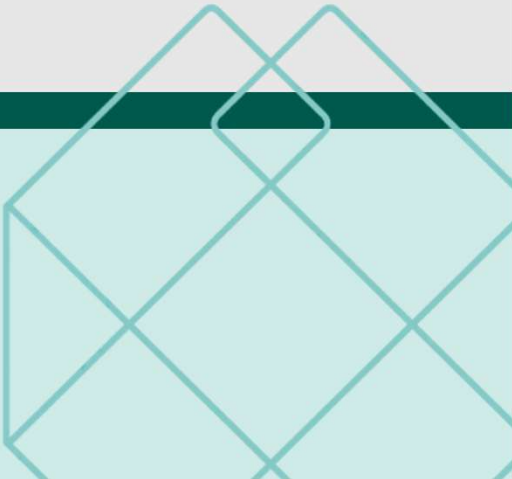
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Final Report

Lower Keys Medical Center

Engagement Overview



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Engagement Overview

VMG Holdings LLC d/b/a VMG Health ("VMG") has been engaged by Akerman LLP ("Akerman" or "Counsel") on behalf of its client Lower Florida Keys Hospital District ("Client" or "District") to provide (1) a third-party, independent fair market value ("FMV") analysis of Lower Keys Medical Center ("Hospital") (the "Fair Market Value Analysis of the Hospital"), and (2) an operational benchmarking (the "Operational and Quality Benchmarking Analysis") and community benefit analysis (the "Community Benefit Analysis") for the Hospital, pursuant to the standards and guidelines established by Florida Statute § 155.40 (5)(c) and (d), respectively.

Pursuant to Florida Statute § 155.40 (5)(c), we understand Client or an affiliated entity is required to "Contract with a certified public accounting firm or other firm that has substantial expertise in the valuation of hospitals to render an independent valuation of the hospital's fair market value." Further, pursuant to Florida Statute § 155.40 (5)(d), we understand Client or an affiliated entity is required to "Consider an objective operating comparison between a hospital or health care system operated by the district, county, or municipality and other similarly situated hospitals, both not-for-profit and for-profit, which have a similar service mix, in order to determine whether there is a difference in the cost of operation using publicly available data provided by the Agency for Health Care Administration and the quality metrics identified by the Centers for Medicare and Medicaid Services Core Measures. The comparison must determine whether it is more beneficial to taxpayers and the affected community for the hospital to be operated by a governmental entity, or whether the hospital can be operated by a not-for-profit or for-profit entity with similar or better cost-efficiencies or measurable outcomes identified by the Centers for Medicare and Medicaid Services Core Measures. The comparison must also determine whether there is a net benefit to the community to operate the hospital as a not-for-profit or for-profit entity and use the proceeds of the sale or lease for the purposes described in this section."

This Fair Market Value Analysis of the Hospital component of this engagement is a "Valuation Engagement" prepared in accordance with the Professional Standards ("Professional Standards"), developed, interpreted, and amended by the National Association of Certified Valuation Analysts ("NACVA"). Pursuant to NACVA guidelines, a Valuation Engagement requires that a member/credentialed designee apply valuation approaches or methods deemed in the member's/credentialed designee's professional judgment to be appropriate under the circumstances and results in a Conclusion of Value. The Fair Market Value Analysis of the Hospital performed has been disclosed herein in a manner consistent with the requirements of a "Summary Report", as defined by NACVA Professional Standards.

The Operational and Quality Benchmarking and Community Benefit Analysis components of this engagement are, collectively, "Financial Consultation and Advisory Services" prepared in accordance with the Professional Standards, developed, interpreted, and amended by NACVA. Financial Consultation or Advisory Services do not involve the expression of an opinion value, nor is the primary or ultimate objective to express an opinion of value. Examples include, but not limited to, fairness opinions, solvency opinions, pricing of securities for public offerings, feasibility studies, transfer pricing studies, lifing studies of intangibles, estate planning or estate tax services, economic damage analysis and quantification, litigation consulting, royalty rate studies for intangibles, and similar engagements. The Operational and Quality Benchmarking and Community Benefit Analysis performed has been disclosed herein in a manner consistent with the requirements of a "Summary Report", as defined by NACVA Professional Standards.



Engagement Overview, Continued

Appraisal Firm	VMG Holdings LLC d/b/a VMG Health ("VMG")
Signatory Appraiser	William Teague, CFA, CVA
Contributing Appraiser(s)	Colin McDermott, CFA, CPA/ABV; Madi Whyde; and Maggie Perry
Client	Akerman LLP ("Counsel" or "Client")
Client Contact(s)	Felicia Nowels, Partner, Akerman LLP
Intended Users	Only Client is the intended user of and may rely on this Summary Report. Client may not substitute the Summary Report for its own due diligence. Client may provide a copy of the Summary Report to its legal counsel, federal or state regulatory authorities, as required by law, or to other third-party advisors, provided such other third-party advisors execute a third-party access letter, which shall be timely and not unreasonably withheld. Receipt or use of the Summary Report by any third party does not create any third-party beneficiary rights. Client is a public entity, and as such, the Summary Report will be subject to Florida's public records law once it is provided by Counsel to Client.
Identification of the Subject Being Valued	Lower Keys Medical Center (the "Hospital"), exclusive of the assets, liabilities, and operations of the DePoo Medical Building and all other ancillary clinics and/or locations
Description of the Interest Being Valued	Business Enterprise Value ("BEV") of the Hospital
Ownership Size, Nature, Restrictions, and Agreements	See Page 10 for Situational Analysis
Purpose of NACVA Valuation Engagement	The purpose of this engagement is to satisfy the requirements of House Bill 711 by performing a FMV opinion of the Business Enterprise Value ("BEV") of the Hospital and operational benchmarking and community benefit analysis pursuant to the standards of Florida Statute § 155.40 (5)(c)
Valuation Date	Tuesday, June 16, 2026
Report Distribution Date	Monday, June 29, 2026
Standard of Value and Definition	Fair Market Value ("FMV"); See Page 8 for Definition
Premise of Value	Going Concern Value
Scope Limitations	See Page 15 for Qualifying Assumptions
Material Matters Considered	See Page 15 for Qualifying Assumptions
Reliance on a Specialist	n/a
Jurisdictional Exceptions and Requirements	n/a
Site Visit Disclosure	No appraisers personally inspected the property subject to this Summary Report.



Standard of Value

The standard of value relied upon for the purposes of this engagement is fair market value ("FMV") as defined by Florida Statute § 155.40 (4)(b). According to Florida Statute § 155.40 (4)(b), fair market value is defined as "...the price that a seller or lessor is willing to accept and a buyer or lessee is willing to pay on the open market and in an arms-length transaction, or what an independent expert in hospital valuation determines the fair market value to be."⁽¹⁾

Consistent with the definition of fair market value as defined by Florida Statute § 155.40 (4)(b), VMG also considered the definition of fair market value as established by Revenue Ruling 59-60, 1959-1, C.b. 237 and the International Glossary of Business Valuation Terms. According to Revenue Ruling 59-60, 1959-1, C.b. 237, fair market value is defined as "...the price at which the property would change hands between a willing buyer and a willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge of relevant facts. Court decisions frequently state in addition that the hypothetical buyer and seller are assumed to be able, as well as willing, to trade and to be well informed about the property and concerning the market for such property."⁽²⁾ The International Glossary of Business Valuation Terms defines fair market value as "the price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arms length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts."⁽³⁾

Further, a determination of fair market value, being a question of fact, will depend on the circumstances of each case. In reaching the Conclusion(s) of Value, VMG considered the following factors cited from Revenue Ruling 59-60, 1959-1, C.b. 237:

- (a) The nature of the business and the history of the enterprise from its inception.
- (b) The economic outlook in general and the condition and outlook of the specific industry in particular.
- (c) The book value of the stock and the financial condition of the business.
- (d) The earning capacity of the company.
- (e) The dividend-paying capacity.
- (f) Whether or not the enterprise has goodwill or other intangible value.
- (g) Sales of the stock and the size of the block of stock to be valued.
- (h) The market price of stocks of corporations engaged in the same or a similar line of business having their stocks actively traded in a free and open market, either on an exchange or over-the-counter.

Additionally, VMG considered the legal and regulatory environment surrounding healthcare. Because Medicare funding could trigger a review of transactions between referring parties, several relevant bodies of law guide the determination of value. The federal Anti Kickback Statute, which prohibits paying for patient referrals, and the Stark self-referral law ("Stark Law"), which limits certain physician referrals, are two laws guiding healthcare's legal and regulatory environment. Within these bodies of law, the government stipulates that stated value in agreements between referring parties must be set at FMV. Based on the guidelines established by the Stark regulations, VMG has expanded the definition of FMV to encompass general market value ("GMV"). Under Stark, FMV is defined as "the value in an arm's-length transaction, consistent with the general market value of the subject transaction", and GMV is defined as "the price that an asset would bring on the date of acquisition of the asset as the result of bona fide bargaining between a well-informed buyer and seller that are not otherwise in a position to generate business for each other."⁽⁴⁾ ⁽⁵⁾



Valuation Methodologies

To follow the general guidelines in IRS Revenue Ruling 59-60, the Stark Law, and the Anti-Kickback Statute, VMG's investigation and analysis included the following:

- Interviews with management about past, present, and prospective operating results of the Hospital;
- Analysis of the financial condition and historical operating and financial performance of the Hospital;
- Consideration of the general economic outlook and the outlook for the Hospital's specific specialty and market area; and,
- Estimates of the earning and dividend-paying capacity of the Hospital, with the assistance of company personnel.

The appraisal of any asset, security, or service is a matter of informed judgement. In arriving at the Conclusion(s) of Value, VMG applied generally accepted valuation procedures based on economic and market factors. Specifically, three generally accepted methodologies were considered: the Cost Approach, the Market Approach, and the Income Approach. These three approaches are outlined as follows:

- **Cost Approach:** The Cost Approach is a general way of determining a value indication of an individual asset by quantifying the amount of money required to replace the future service capability of that asset.
- **Market Approach:** The Market Approach is a general way of determining a value indication of a business, business ownership interest, security or intangible asset by using one or more methods that compare the subject to similar businesses, business ownership interests, securities or intangible assets that have been sold.
 - **Guideline Public Company Method:** The Guideline Public Company ("GPC") Method is a method within the market approach whereby market multiples are derived from market prices of stocks of companies that are engaged in the same or similar lines of business, and that are actively traded on a free and open market.
 - **Merger and Acquisition Method:** The Merger and Acquisition ("M&A") Method is a method within the market approach whereby pricing multiples are derived from transactions of significant interests in companies engaged in the same or similar lines of business.
- **Income Approach:** The Income Approach is a general way of determining the value indication of a business, business ownership interest, security or intangible asset using one or more methods that convert anticipated future economic benefits or revenue into a present value single amount.

Notes and Sources

- (1) Source(s): 2024 Florida Statutes (Including 2025C) (<https://www.flsenate.gov/Laws/Statutes/2024/155.40>)
- (2) Source(s): Rev. Rul. 59-60; 1959-1 C.B. 237
- (3) Source(s): <https://www.nacva.com/glossary>
- (4) Source(s): 42 CFR 411.351 "Fair market value", [https://www.ecfr.gov/current/title-42/part-411/section-411.351#p-411.351\(Fair%20market%20value\)](https://www.ecfr.gov/current/title-42/part-411/section-411.351#p-411.351(Fair%20market%20value))
- (5) Source(s): 42 CFR 411.351 "General market value", [https://www.ecfr.gov/current/title-42/part-411/section-411.351#p-411.351\(General%20market%20value\)](https://www.ecfr.gov/current/title-42/part-411/section-411.351#p-411.351(General%20market%20value))



Description of the Subject Entity

- Lower Keys Medical Center ("LKMC" or "Hospital") is an acute care hospital located at 5900 College Road, Key West, Florida 33040. It is owned by The Lower Florida Keys Hospital District (the "District") and currently operated by Community Health Systems, Inc. ("CHS"). The District was created by special act of the Florida legislature (the "Enabling Legislation") in 1967 for the purpose of creating, staffing, and operating a hospital in the Lower Florida Keys for the benefit of the residents of the District. The District is authorized to levy ad valorem millage on the homeowner residents of the District to help fund the indigent health care obligations of the District. Through April 30, 1989, the District operated the Hospital, then known as Florida Keys Memorial Hospital ("FKMH").
- In the 1980s, the District found itself competing with DePoo Hospital for a finite number of healthcare professionals in the community and for the purchase of expensive new technological equipment. DePoo Hospital, which was constructed and operated within the same service area as FKMH, and was, at the time, a for-profit hospital owned by Kennedy Drive Investors, Ltd ("Kennedy Drive"). In response, the District and Kennedy Drive consolidated the operations of FKMH and DePoo Hospital in May of 1989, resulting in the formation of the Lower Florida Keys Health System ("Health System"), a non-profit Florida corporation. Each of the District and Kennedy Drive entered into thirty (30)-year leases with the Health System pursuant to which they each leased their land, buildings, and equipment. The two facilities applied to State of Florida, Agency for Health Care Administration ("AHCA") and received licensure as a singular hospital system, but different certificate numbers and file numbers for each facility, with one set of Bylaws, a combined medical staff, and a singular administrative and employed staff. As a result of this combination, the Health System achieved rural health designation from CMS as a sole community provider. As part of its obligations, the Health System assumed the obligation of providing all the indigent care that the District was required to provide by its Enabling Legislation, for which the District reimbursed the Health System. Services were shifted such that the FKMH facility provided acute care, and the DePoo facility focused on behavioral health services.
- During the late 1990s, however, due to circumstances including, but not limited to, the proliferation of managed care arrangements resulting in arbitrarily reduced payments regardless of charges; increased competition from proprietary enterprises that siphoned off the paying outpatients from the Health System; the increasing number of younger residents living within the District without the ability to pay for requisite healthcare; and the increased capital needs for physical plant and equipment, the Health System revenues declined. As a result, the District undertook a process to identify potential lessees/operators of the Health System facilities, which ultimately resulted in the determination that Health Management Associates ("HMA") (which subsequently was acquired by CHS, the current operator) was the preferred operator/lessee of choice. New thirty (30)-year leases for each of the District and Kennedy Drive were entered into, effective May 1, 1999, with Key West HMA, Inc. and The District Hospital facility was re-branded as Lower Keys Medical Center ("LKMC" or "Hospital").
- The District currently intends to undergo a request for proposal ("RFP") process to engage interest, capabilities, and partnership opportunities with qualified entities to operate the Hospital through a long-term lease with the District. We understand this analysis will assist the governing board of the District in evaluating the possible benefits to the community from the sale or lease of the Hospital in accordance with regulatory guidelines and processes.

Notes and Sources

(1) Source(s): Draft Request for Proposal ("RFP") provided by Client in the file "Draft RFP LFKHD CLEAN DRAFT 6.2.26.docx"



Description of the Subject Entity, Continued

- LKMC currently provides access to a comprehensive range of healthcare services, including heart care featuring an Accredited Chest Pain Center, cardiac catheterization services, critical care medicine, and 24/7 emergency services. Additional offerings include behavioral health, cancer care, and maternity and labor and delivery services. The organization also provides rehabilitation services and a broad spectrum of surgical specialties, including ENT, orthopedic, robotic, endoscopy, vascular, and other procedures. Diagnostic imaging, including general diagnostic imaging, MRI, mammography, CT scanning, nuclear imaging and ultrasound services, and neurology services are available, along with primary care to support ongoing patient health and wellness.
- Built in 1967, LKMC's main hospital facility is a 95,000-square-foot, three-story building designed to support both inpatient and outpatient care. As mentioned previously, the hospital is licensed for 118 beds, including 103 acute care beds and 15 beds for the skilled nursing unit, allowing the organization to support patients across multiple levels of care. Within the facility, 12,529 square feet are dedicated to the medical/surgical unit, which supports core inpatient services and accommodates a significant portion of the hospital's acute care capacity.
- **Emergency Department:** The LKMC emergency department occupies 3,914 square feet and includes six exam rooms, a dedicated triage area, two special procedures rooms, and a behavioral health room. The department provides emergency care 24 hours a day, seven days a week. The ED was last renovated in 2008 as part of a broader upgrade that also included the catheterization laboratory.
- **Surgical Department:** The surgical department occupies 9,314 square feet and includes four operating rooms, one of which is equipped for Cesarean sections, as well as two endoscopy rooms. The department also features a dedicated decontamination room and a sterile processing area to support surgical operations. Pre- and post-operative care areas include three preoperative beds, six post-anesthesia care unit ("PACU") bays, and one PACU isolation room. For outpatient procedures, the department provides eight pre- and post-operative rooms with a total of 11 beds, as well as 10 outpatient surgery overflow rooms accommodating an additional 13 beds. The surgical suite was last renovated in 2002.
- **Laboratory and Radiology Department:** LKMC's laboratory and imaging services occupy 8,727 square feet and support both inpatient and outpatient care. The department provides a full range of diagnostic capabilities, including laboratory testing, general diagnostic imaging, MRI, mammography, CT scanning, nuclear imaging, and ultrasound services. In 2018, the Women's Imaging Center was expanded by adding two new suites, enhancing the hospital's capacity to deliver specialized imaging services for women's health.
- LKMC has a medical staff of 70 active providers and 28 allied health professionals across a variety of specialties. LKMC also has access to telemedicine providers within nephrology, neurology and radiology.

Notes and Sources

(1) Source(s): Draft Request for Proposal ("RFP") provided by Client in the file "Draft RFP LFKHD CLEAN DRAFT 6.2.26.docx"



Summary of Title XI, Chapter 155, Section 40 - Sale or Lease of County, District, or Municipal Hospital; Effect of Sale

155.40 Sale or lease of county, district, or municipal hospital; effect of sale. –

- (1) In the interest of providing quality health care services to the citizens and residents of this state, and notwithstanding any other provision of general or special law, a county, district, or municipal hospital organized and existing under the laws of this state, acting by and through its governing board, may sell or lease the hospital to a for-profit or not-for-profit Florida entity, and enter into leases or other contracts with a for-profit or not-for-profit Florida entity for the purpose of operating the hospital and its facilities. The term of such lease, contract, or agreement and the conditions, covenants, and agreements to be contained therein shall be determined by the governing board of the hospital. The governing board of the hospital must find that the sale, lease, or contract is in the best interests of the affected community and must state the basis of that finding.
- (2) A lease, contract, or agreement made pursuant hereto shall:
 - (a) Provide that the articles of incorporation of the for-profit or not-for-profit corporation be subject to the approval of the board of directors or board of trustees of the hospital;
 - (b) Require that any not-for-profit corporation become qualified under s. 501(c)(3) of the United States Internal Revenue Code;
 - (c) Provide for the orderly transition of the operation and management of the facilities;
 - (d) Provide for the return of the facility to the county, municipality, or district upon the termination of the lease, contract, or agreement; and
 - (e) Provide for the continued treatment of indigent patients pursuant to the Florida Health Care Responsibility Act and pursuant to chapter 87-92, Laws of Florida.
- (5) The governing board of a county, district, or municipal hospital or health care system shall commence an evaluation of the possible benefits to an affected community from the sale or lease of hospital facilities owned by the board to a not-for-profit or for-profit entity no later than December 31, 2012. In the course of evaluating the benefits of the sale or lease, the board shall:
 - (c) Contract with a certified public accounting firm or other firm that has substantial expertise in the valuation of hospitals to render an independent valuation of the hospital's fair market value.
 - (a) Consider an objective operating comparison between a hospital or health care system operated by the district, county, or municipality and other similarly situated hospitals, both not-for-profit and for-profit, which have a similar service mix, in order to determine whether there is a difference in the cost of operation using publicly available data provided by the Agency for Health Care Administration and the quality metrics identified by the Centers for Medicare and Medicaid Services Core Measures. The comparison must determine whether it is more beneficial to taxpayers and the affected community for the hospital to be operated by a governmental entity, or whether the hospital can be operated by a not-for-profit or for-profit entity with similar or better cost-efficiencies or measurable outcomes identified by the Centers for Medicare and Medicaid Services Core Measures. The comparison must also determine whether there is a net benefit to the community to operate the hospital as a not-for-profit or for-profit entity and use the proceeds of the sale or lease for the purposes described in this section.

Notes and Sources

- (1) Source(s): 2024 Florida Statutes (Including 2025C) (<https://www.flsenate.gov/Laws/Statutes/2024/155.40>)



Description of the Prior Lease Arrangement

The following section details key terms of the Lease Agreement, as amended, by and between The Lower Florida Keys Hospital District ("Lessor") and Key West HMA, Inc. ("Lessee").

- Article I, Recitals, Definitions, and Demise

1.2 Definitions. The following terms, when used in this Lease, shall have the following meaning:

- "Excluded Assets" means, collectively:
 - Cash, cash deposits with banks and escrows, and all other cash equivalent items of Lessee;
 - Lessee's corporate and fiscal records and other records pertaining to the operation of the District Hospital by Lessee which Lessee is required by law to retain in its possession to the extent that such records are not necessary for the operation of the District Hospital by Lessor;
 - All refunds and reimbursements for periods within the Lease Term, even if payable after the expiration of the Lease Term, available from insurers, third party payors, Medicaid and Medicare under applicable rules and regulations and other comparable programs;
 - All accounts receivable that exist and are available to the Lessee for periods on or prior to the expiration or termination of the Lease; and
 - All notes payable held by Lessee as of the date of the expiration or termination of the Lease, including notes signed by physicians.
- "Personal Property Assets" means all furniture furnishing, equipment, machinery, data processing, hardware, software, vehicles and other tangible and intangible property owned by Lessor or Health System and used in connection with the District Hospital and all assignable and transferable licenses, permits, registrations, certificates, consents, accreditation, approvals and franchises, including rights to the name "Florida Keys Memorial Hospital", and all rights to a total of one hundred eighteen (118) licensed hospital beds (the "Licensed Hospital Beds") used in connection with the District Hospital, all of which have been assigned, conveyed, transferred and sold to Lessee by Health System and sold or leased to Lessee by District contemporaneous with the signing of this Lease Agreement, and all replacements and substitutions therefor, and all other tangible and intangible personal property including furniture, fixtures, equipment, inventories, and medical records necessary for the operations of the District Hospital now or hereafter located on the Leased Premises (other than personal property purchased by Lessee within the last five (5) years of the Lease Term which personal property shall be purchased by Lessor upon expiration of the Lease Term or early termination thereof as provided for herein to the extent described in Section 3.2 hereof), all goodwill associated with the District Hospital, and all assignable warranties (expressed or implied), all patents and patent applications held by Lessor associated with the District Hospital, all trademarks or trade names and copyrights of Lessor pertaining to the District Hospital, and any proprietary manuals pertaining to the District Hospital.

Notes and Sources

- (1) Source(s): Lease Agreement by and between The Lower Florida Keys Hospital District and Key West HMA, Inc., dated May 1, 1999, provided by Client in the file "LFKHD LeaseAgreement 1999 05 01.pdf"



Description of the Prior Lease Arrangement, Continued

The following section details key terms of the Lease Agreement, as amended, by and between The Lower Florida Keys Hospital District ("Lessor") and Key West HMA, Inc. ("Lessee").

3.2 Expiration or Termination of Lease.

- a. Upon the expiration of the Lease Term or earlier termination of this Lease by a Judicial Determination in the event of a material default by Lessee hereunder or under Lessee's sublease of the DePoo Hospital from Kennedy Drive, and in accordance with the terms and provisions of Section 10.2(b) hereof, Lessee shall for no consideration relinquish and surrender to Lessor possession of the Leased Premises and Lessee shall convey to Lessor by quit claim deed all of its interest in the Leased Premises, including, without limitation, the District Hospital and shall convey and/or transfer to Health System by (i) assignment without warranties all of District Hospital licenses, certificates and permits for the District Hospital, including, but not limited to, the certificates of need and rights to the Licensed Hospital Beds, and (ii) by bill of sale without warranties of all the Personal Property Assets, free and clear of any Taxes (except as to ad valorem taxes, if any, for the balance of the year of closing hereunder), indebtedness, liens or encumbrances, but such conveyances and transfers shall be subject to (a) the Permitted Encumbrances, (b) all restrictions, covenants, reservations, and easements placed of record by Lessee with Lessor's consent, (c) ad valorem taxes, if any, for the balance of the year of the transfer, and (d) all applicable zoning and land use restrictions.
- b. It is the intention of the parties to this Lease that in the event of the expiration of the Lease Term or earlier termination of this Lease by a Judicial Determination in the event of a material default by Lessee under the Lease Agreement, that the Leased Premises, in accordance with Section 10.2(b) hereof, be immediately released to the Lessor and all Personal Property Assets necessary for the immediate and continued operation of the District Hospital by Health System as an acute care hospital be conveyed, transferred, or assigned (other than the Excluded Assets) or to the extent not transferable or assignable made available to Health System, including, but not limited to, all licenses and permit held by the Lessee, for the operation of the District Hospital.
- c. Notwithstanding any other terms to the contrary, any equipment purchased by Lessee during the last five (5) years of the Lease Term (or within five (5) years of an earlier termination date) other than equipment purchased in the thirtieth (30th) year of the Lease Term shall be purchased by and sold to Health System or Lessor, if applicable, on the date of expiration of the Lease for its remaining book value as determined by GAAP. As to equipment acquired in the thirtieth (30th) year of the Lease Term, and solely as to such equipment, the Lessor shall have an option to acquire such equipment at book value as determined by GAAP.

Notes and Sources

- (1) Source(s): Lease Agreement by and between The Lower Florida Keys Hospital District and Key West HMA, Inc., dated May 1, 1999, provided by Client in the file "LFKHD LeaseAgreement 1999 05 01.pdf"
- (2) Source(s): Lease Agreement Amendment by and between The Lower Florida Keys Hospital District and Key West HMA, Inc., dated October 1, 2001, provided by Client in the file "LFKHD Lease Agreement Amendment One 2002 04 15.pdf"
- (3) Source(s): Second Lease Agreement Amendment by and between The Lower Florida Keys Hospital District and Key West HMA, Inc., dated October 1, 2003, provided by Client in the file "LFKHD Lease Agreement Amendment Two 2003 10 01.pdf"



Amendment of any assumption qualified below could materially impact any Conclusion(s) of Value presented herein.

Notable Items Influencing the Valuation Engagement

1. VMG reviewed the Hospital's financials for the last three years and through December 31, 2025. Although requested, VMG did not receive any historical or financial data for any year-to-date period for 2026. Diligence communication was held through June 26, 2026, and the Valuation Date is June 26, 2026. VMG has assumed that nothing material has changed since the latest diligence communication.
2. Based on discussions with Client, the scope of this analysis is restricted to the operations of Lower Keys Medical Center only, and specifically excludes all assets, liabilities, and operations associated with the DePoo Medical Building (which provides behavioral health services for the Hospital's patients), a consolidated ambulatory surgery center ("ASC"), and ancillary clinics. VMG was provided financial information for the last three years and through December 31, 2025 for the Hospital on a consolidated basis (i.e., inclusive of assets, liabilities, and operations associated with DePoo, the ASC, and ancillary clinics). VMG was only provided information for fiscal years ("FY") 2024 and 2025 to enable the isolation of operations related solely to the Hospital subject to this analysis. Therefore, historical balance sheets, income statements, and other operating data for FY 2022 and 2023 were not included in our analysis. According to Hospital management, the Hospital's ancillary clinic assets may generate net operating losses. To the extent the lessee is required to fund any losses related to the ancillary clinics, or receive the profits from the ASC and/or DePoo as part of the future lease, the FMV opinion may be impacted. The following section details the procedures utilized to isolate the Hospital's FY 2024 and 2025 financial and operational information:
 - For FY 2024 and 2025, VMG was provided income statements specific to the reporting unit "1005", which we understand excludes operations associated with the ASC and ancillary clinics, but includes operations associated with both Lower Keys Medical Center and the DePoo facility. VMG was provided income statements for the "Inpatient Behavioral Health Departments", which we understand relates solely to DePoo facility operations. In order to derive a financial view of Hospital operations only, VMG subtracted the "Inpatient Behavioral Health Departments" income statement line items from the "1005" income statement for FY 2024 and FY 2025.
 - Based on discussions with Hospital management, "ASC surgeries" and "clinic visits" reflect operations associated with the DePoo facility, ASC, and ancillary clinic operations. These volume metrics were excluded in FY 2024 and 2025 accordingly.
 - For FY 2024 and 2025, VMG was provided balance sheets specific to the reporting unit "1005", which we understand excludes operations associated with the ASC and ancillary clinics, but includes operations associated with both Lower Keys Medical Center and the DePoo facility. Based on discussions with Hospital management, there is no definitive way to exclude assets and/or liabilities from the "1005" balance sheets. However, VMG understands all interest-bearing debt outstanding is related entirely to the DePoo facility. Therefore, interest-bearing debt has been adjusted out of the December 31, 2025 balance sheet.
 - VMG was provided a fixed asset ledger for the reporting unit "1005". Per direction from Hospital management, VMG identified assets with the term "DePoo" indicated in the asset description to isolate fixed assets specific to DePoo behavioral health services. The net balances of these assets according to the provided fixed asset ledger were removed from the December 31, 2025 "1005" balance sheet in order to estimate total Net Fixed Assets associated with solely with the Hospital.
3. The indications of Fair Market Value presented in this analysis assume a transaction involving a Control level of value.
4. Included within the FMV indication are all operating assets including normalized working capital, fixed assets, and intangible assets. Normalized working capital includes accounts receivable, and other current assets, less current liabilities, that permit a business to conduct day-to-day operations and maintain liquidity. Based on VMG experience in the subject's industry and publicly traded companies, the normalized working capital is estimated at 5.4% of normalized net operating revenue as of the Valuation Date. VMG assumed the historical working capital per the balance sheet may not be reflective of net working capital due to intercompany accounting and DePoo.



Amendment of any assumption qualified below could materially impact any Conclusion(s) of Value presented herein.

Notable Items Influencing the Valuation Engagement, Continued

5. Projected Depreciation and Amortization Expense was modeled by calendar year, assuming a hypothetical control transaction using an asset deal structure. VMG assumed a hypothetical buyer would follow the guidelines established by IRS Publication 946, How to Depreciate Property (i.e., the Modified Accelerated Cost Recovery System ("MACRS") depreciation), including the application of Section 179 Deductions and Section 168(k) Expenses (i.e., the "Special Depreciation Allowance" or "Bonus Depreciation"), where applicable. The One Big Beautiful Bill Act ("OBBBA"), enacted into law on July 4, 2025, allows for 100.0% expensing (i.e., Bonus Depreciation) for certain property acquired after January 19, 2025. Please note, state and local tax ("SALT") considerations as it relates to Section 179 and Section 168(k) were not implemented to align with a broader market participant perspective.
6. According to documentation provided by the District, the Hospital was constructed in the late 1960s and has been maintained, but has aged over time. Further, while the existing facility can support immediate hospital operations, there is an opportunity to develop a new health facility that reflects state-of-the-art approaches to patient care, including the increasing prevalence of outpatient care modalities, new technologies and equipment, and emerging adjacency opportunities (i.e., "Hospital Modernization"). To account for the Hospital Modernization need, VMG adjusted the Fair Market Value Indication of the Hospital for an "Assumed Cost of Modernization of Hospital". The Assumed Cost of Modernization of Hospital was calculated in range based on the "Replacement Value" of the Hospital as reported in the Engineering Report provided by District, discussions with Client and the representations of their advisors. Please note, these costs may not include the required furniture, fixtures, and equipment, which may be incremental to the cost estimates. These cost estimates were inflation-adjusted, and VMG assumed the Hospital Modernization may begin in ten (10) years, and take approximately three (3) years to complete. These inflation-adjusted costs were discounted to present value using a discount rate consistent with the current cost of debt. VMG has not opined on the replacement value of the Hospital. To the extent that estimates from third parties are inaccurate, the FMV opinion may be impacted. Additionally, VMG has assumed that a hypothetical lessee will enter into a long-enough term lease with the District to earn a return on its investment on any Hospital Modernization efforts, and fund all of the capital necessary. To the extent that the District funds any capital related to Hospital Modernization, the valuation opinion may be materially impacted. VMG has assumed that there will be no disruptions to operations as part of any Hospital Modernization endeavors. Please see the Hospital Modernization Costs section herein for details.
7. Pursuant to the Income Approach, VMG performed a multi-period discounted cash flow ("DCF") analysis utilizing a five-year projection and into perpetuity. This methodology was deemed appropriate, as a typical market participant would likely enter a long-term lease with the District. Further, consistent with the guidelines established by Title XI, Chapter 155, Section 40 - Sale or Lease of County, District, or Municipal Hospital; Effect of Sale of Florida regulations, a lease, contract, or agreement made shall provide for the orderly transition of the operation and management of the facilities. Therefore, any disruption in operations in the event the parties to a lease arrangement for the Hospital has not been explicitly included in the determination of Fair Market Value. VMG further notes that the costs associated with transition services in the event of a transaction are inherently included in the market approach multiples reviewed and considered pursuant to this analysis.
8. A corporate income tax of 25.35% was utilized in the analysis, which we have calculated to be reflective of a blended federal and state rate of United States income earned in Florida. Discount rates used in the valuation are market-based and derived, in part, from publicly traded companies. These for-profit companies result in a market-based discount rate after-tax. Therefore, Normalized Base Year earnings of the subject entity are tax-affected using the tax rate in order to match the expected future cash flows with the cash flow stream being discounted.
9. Our analysis assumes a hypothetical transaction between a willing buyer and a willing seller, operating under typical market conditions. Therefore, any projections herein include the assumption of a non-compete arrangement between a hypothetical willing and able buyer and seller.



Amendment of any assumption qualified below could materially impact any Conclusion(s) of Value presented herein.

Notable Items Influencing the Valuation Engagement, Continued

- 10. Our analysis considers the One Big Beautiful Bill Act ("OBBA") impact in our discount rate.
- 11. VMG has assumed that a typical buyer would incur normal capital expenditure levels over time excluding the impact of the hospital modernization, at approximately 3.5% of revenue.



Amendment of any assumption qualified below could materially impact any Conclusion(s) of Value presented herein.

Disclosure of Subsequent Events

Events or transactions sometimes occur subsequent to the balance sheet date, but prior to the issuance of the financial statements, that have a material effect on the financial statements and therefore require adjustment or disclosure in the statements. These occurrences are referred to as "subsequent events." The following subsequent events have been identified for the purposes of this analysis:

1. Per discussions with Hospital management, there have been no material changes in the outlook, financial position, or business operations of the Hospital as of the Valuation Date.

Hypothetical Conditions

According to USPAP, "Hypothetical conditions are contrary to known facts about physical, legal, or economic characteristics of the subject property; or about conditions external to the property, such as market conditions or trends; or about the integrity of data used in an analysis." A hypothetical condition may be used by a valuation analyst in an assignment if (1) use of the hypothetical condition is clearly required for legal purposes, for purposes of reasonable analysis, or for purposes of comparison; (2) use of the hypothetical condition results in a credible analysis; and, (3) the appraiser complies with the disclosure requirements set forth in USPAP for hypothetical conditions. The following hypothetical conditions were utilized for the purposes of this analysis:

1. No hypothetical conditions were utilized for the purposes of this analysis.

Extraordinary Assumptions

According to USPAP, an extraordinary assumption is defined as "...an assumption, directly related to a specific assignment, as of the effective date of the assignment results, which, if found to be false, could alter the appraiser's opinions or conclusions." An extraordinary assumption may be used by a valuation analyst in an assignment if (1) it is required to properly develop credible opinions and conclusions; (2) the appraiser has a reasonable basis for the extraordinary assumption; (3) the use of the extraordinary assumption results in a credible analysis; and, (4) the appraiser complies with the disclosure requirements set forth in USPAP for extraordinary assumptions. The following extraordinary assumptions were utilized for the purposes of this analysis:

1. No extraordinary assumptions were utilized for the purposes of this analysis.

Notes and Sources

- (1) Source(s): "2014-2015 Uniform Standards of Appraisal Practice," Appraisal Standards Board The Appraisal Foundation (2014)



Final Report

Lower Keys Medical Center

Executive Summary

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Conclusion(s) of Value (All Dollar Figures Rounded)	Low	Midpoint	High	Key Assumptions
Fair Market Value of the Business Enterprise, Including a Normalized Level of Working Capital, Control Level	\$245,400,000	\$258,300,000	\$271,200,000	Notes and Sources (1)
Less: Normalized Working Capital Retained by the Current Lessee	(\$6,793,000)	(\$6,793,000)	(\$6,793,000)	Notes and Sources (2)
Fair Market Value of the Hospital's Business Enterprise Value, Excluding a Normalized Level of Working Capital, Control Level	\$238,607,000	\$251,507,000	\$264,407,000	
Less: Assumed Cost of Modernization of Hospital	(\$110,400,000)	(\$82,800,000)	(\$55,100,000)	Notes and Sources (3)
Fair Market Value of the Hospital's Business Enterprise Value, Excluding a Normalized Level of Working Capital, Control Level	\$128,207,000	\$168,707,000	\$209,307,000	

Implied Market Multiples	Financial Metric	Low	Midpoint	High
BEV / NBY EBITDA	\$35,599,470	6.9x	7.3x	7.6x
Hospital Adjusted-BEV / NBY EBITDA	\$35,599,470	3.6x	4.7x	5.9x

Notes and Sources

- (1) Business Enterprise Value ("BEV") includes all operating assets, comprising fixed assets, identified intangible assets, and normalized cash-free working capital. Cash-free working capital is defined as current assets excluding cash (supplies, inventory, accounts receivable, etc.) minus current liabilities (trade payables, accrued short-term liabilities, etc.).
- (2) According to the Lease Agreement, working capital is included within the definition of "Excluded Assets", and will not transfer to the District upon the expiration of the Lease Agreement. Therefore, working capital has been excluded from the Business Enterprise Value indication.
- (3) According to documentation provided by the District, the Hospital was constructed in the late 1960s and has been maintained, but has aged over time. Further, while the existing facility can support immediate hospital operations, there is an opportunity to develop a new health facility that reflects state-of-the-art approaches to patient care, including the increasing prevalence of outpatient care modalities, new technologies and equipment, and emerging adjacency opportunities (i.e., "Hospital Modernization"). To account for the Hospital Modernization need, VMG adjusted the Fair Market Value Indication of the Hospital for an "Assumed Cost of Modernization of Hospital". The Assumed Cost of Modernization of Hospital was calculated in range based on the "Replacement Value" of the Hospital as reported in the Engineering Report provided by District, discussions with Client and the representations of their advisors. Please note, these costs may not include the required furniture, fixtures, and equipment, which may be incremental to the cost estimates. These cost estimates were inflation-adjusted, and VMG assumed the Hospital Modernization may begin in ten (10) years, and take approximately three (3) years to complete. These inflation-adjusted costs were discounted to present value using a discount rate consistent with the current cost of debt. VMG has not opined on the replacement value of the Hospital. To the extent that estimates from third parties are inaccurate, the FMV opinion may be impacted. Additionally, VMG has assumed that a hypothetical lessee will enter into a long-enough term lease with the District to earn a return on its investment on any Hospital Modernization efforts, and fund all of the capital necessary. To the extent that the District funds any capital related to Hospital Modernization, the valuation opinion may be materially impacted. VMG has assumed that there will be no disruptions to operations as part of any Hospital Modernization endeavors. Please see the Hospital Modernization Costs section herein for details.
- (4) Please note that all dollar figures presented above are rounded.



Value Indications by Methodology and Reconciliation		Value	Weight	Conclusion	Key Assumptions
Income Approach	Discounted Cash Flow Multi-Period Method	\$249,621,267	50.0%	\$124,810,633	13.0% Estimated Weighted Average Cost of Capital; 2.0% Estimated Long-Term Growth Rate; Page 50
Cost Approach	Build-Up Approach	\$36,131,575	-	-	= Normalized Working Capital + Fixed Assets; Page 57
Market Approach	Guideline Public Company Method	\$249,196,289	-	-	6.0x to 8.0x NBY Revenue; Page 64
Market Approach	Merger and Acquisition Method	\$266,996,024	50.0%	\$133,498,012	5.0x to 10.0x NBY Revenue; Page 66
Midpoint Fair Market Value Indication				\$258,308,645	

Notes and Sources

- (1) Three distinct approaches to value were considered in accordance with generally accepted valuation methodologies; these approaches include the Cost, Market, and Income Approaches. Ultimately, 50.0% reliance was placed upon the Income Approach, utilizing the Discounted Cash Flow ("DCF") Multi-Period Method, and 50.0% reliance was placed upon the Market Approach, utilizing the Merger and Acquisition Method ("M&A Method"). It was our determination that the Cost Approach did not provide adequate consideration to the going concern value of the Hospital. The Guideline Public Company Method ("GPC Method") was a second methodology considered pursuant to a Market Approach, and was utilized as a corroborative approach to the Income Approach and M&A Method.
- (2) All value indications include a normalized level of working capital.



Operational and Quality Benchmarking Analysis and Community Benefit Analysis Conclusion(s)

• Hospital Operating Cost Comparison

Based on VMG's review of the operating cost metrics between for-profit/not-for profit and government hospitals, there is no definitive distinction in operating efficiency and/or performance between either types of hospital. For-profit/not-for profit operators exceed government operators in certain metrics, while government operators exceed for-profit/not-for profit operators in other metrics. It should be noted, while there are outliers, it is VMG's observation that the identified hospitals are, broadly, relatively aligned across the operating metrics reviewed. Additionally, it should be noted there are fewer district-owned hospitals in the state of Florida today than historically, which may also make comparisons difficult due to sample size. Therefore, considering all the metrics reviewed and subject to the small sample size, it is VMG's conclusion that the analysis does not reveal sufficient evidence to suggest it would be more and/or less beneficial for the Hospital to be run by a government entity than a for-profit and/or not-for-profit entity.

• Hospital Quality Comparison

Based on VMG's review of the quality metrics between for-profit/not-for profit and government hospitals, there is no definitive distinction in the quality of care provided by either types of hospital. For-profit/not-for profit operators exceed government operators in certain metrics, while government operators exceed for-profit/not-for profit operators in other metrics. It should be noted, while there are outliers, it is VMG's observation that the identified hospitals are, broadly, relatively aligned across the quality metrics reviewed. Additionally, it should be noted there are few district-owned hospitals in the state of Florida today than historically, which may also make comparisons difficult due to sample size. Therefore, considering all the metrics reviewed and subject to the small sample size, it is VMG's conclusion that the analysis does not reveal sufficient evidence to suggest it would be more and/or less beneficial for the Hospital to be run by a government entity than a for-profit and/or not-for-profit entity.

• Community Benefit Analysis

The operation of the Hospital by an entity that is not the District is a net benefit to the community, assuming a hypothetical buyer maintains the Hospital's current charity and bad debt levels, currently represented at \$48.6 million and \$14.0 million, respectively, annually. Although the support provided by the District could be used for other purposes within the county, the amount currently provided is relatively insignificant compared to the Total Uncompensated Care provided by the Hospital. We also understand the current level of property taxes paid by the Hospital is estimated at approximately \$96,000 annually according to the Hospital's 2025 estimated property tax level published on the county's tax collector website. However, property taxes may be higher and or lower depending on what is negotiated in the future lease and whether the tax assessment of the facility is updated. In addition, the Hospital may generate sales and other types of taxes, licenses, and fees from a hypothetical operator. Finally, the estimated proceeds from the sale of the Hospital may be significant from the lease of the Hospital and used to create an indigent care fund and/or health care economic fund to the benefit of the local community.

Notes and Sources

- (1) Please refer to page 69 herein for the Operational, Quality, and Community Benefit Analysis
- (2) Please refer to page 126 herein for the Community Benefit Analysis



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Lower Keys Medical Center

Fair Market Value Analysis of the Hospital

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Lower Keys Medical Center

Historical Operations Analysis

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Lower Keys Medical Center

Historical Operations Analysis | Balance Sheet

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		LKMC + DePoo			LKMC Only	Common Size Balance Sheet		
Balance Sheet	Footnotes	Dec. 31, 2024	Dec. 31, 2025	Adjustments	Dec. 31, 2025	Dec. 31, 2024	Dec. 31, 2025	Dec. 31, 2025
Assets								
Current Assets								
Cash and Equivalents		\$1,400	\$1,401	-	\$1,401	0.0%	0.0%	0.0%
Net Accounts Receivable		35,725,045	34,984,348	-	34,984,348	68.9%	60.5%	62.8%
Allowance for Uncollectible Accounts		(17,302,097)	(13,124,128)	-	(13,124,128)	(33.3%)	(22.7%)	(23.6%)
Prior-Year Settlement		86,567	(233,335)	-	(233,335)	0.2%	(0.4%)	(0.4%)
Inventories		2,641,295	2,969,081	-	2,969,081	5.1%	5.1%	5.3%
Prepaid Expenses		691,033	414,491	-	414,491	1.3%	0.7%	0.7%
Other Current Assets		101,610	221,511	-	221,511	0.2%	0.4%	0.4%
		21,944,853	25,233,369	-	25,233,369	42.3%	43.6%	45.3%
Fixed Assets								
Building Improvements	3	28,030,873	32,711,752	(2,091,073)	30,620,679	54.0%	56.5%	55.0%
Equipment and Fixtures	3	28,423,709	31,396,313	(71,836)	31,324,477	54.8%	54.3%	56.2%
Right-of-Use ("ROU") Finance Lease		25,730,000	25,730,000	-	25,730,000	49.6%	44.5%	46.2%
Construction in Progress		186,657	1,585,580	-	1,585,580	0.4%	2.7%	2.8%
Accumulated Depreciation		(54,547,549)	(61,314,228)	-	(61,314,228)	(105.1%)	(106.0%)	(110.1%)
		27,823,690	30,109,417	(2,162,909)	27,946,508	53.6%	52.0%	50.2%
Other Assets								
Right-of-Use ("ROU") Operating Lease		698,714	1,128,386	-	1,128,386	1.3%	2.0%	2.0%
Other Deferred Costs		1,207,815	1,184,895	-	1,184,895	2.3%	2.0%	2.1%
Deferred Miscellaneous Charges		170,833	200,609	-	200,609	0.3%	0.3%	0.4%
Security Deposits		6,700	6,700	-	6,700	0.0%	0.0%	0.0%
Physician Recruitment Costs		34,281	-	-	-	0.1%	-	-
		2,118,343	2,520,590	-	2,520,590	4.1%	4.4%	4.5%
Total Assets		\$51,886,886	\$57,863,376	(\$2,162,909)	\$55,700,467	100.0%	100.0%	100.0%
Growth		n/a	11.5%		(3.7%)			

Notes and Sources

- (1) Sources: VMG utilized unaudited financials provided by the District for the time periods presented.
- (2) For FY 2024 and 2025, VMG was provided balance sheets specific to the reporting unit "1005", which we understand excludes operations associated with the ASC and ancillary clinics, but includes operations associated with both Lower Keys Medical Center and the DePoo facility. Based on discussions with Hospital management, there is no definitive way to exclude assets and/or liabilities from the "1005" balance sheets. However, VMG understands all interest-bearing debt outstanding is related entirely to the DePoo facility. Therefore, interest-bearing debt has been adjusted out of the December 31, 2025 balance sheet.
- (3) VMG was provided a fixed asset ledger for the reporting unit "1005". Per direction from Hospital management, VMG identified assets with the term "DePoo" indicated in the asset description to isolate fixed assets specific to DePoo behavioral health services. The net balances of these assets according to the provided fixed asset ledger were removed from the December 31, 2025 "1005" balance sheet in order to estimate total Net Fixed Assets associated with solely with the Hospital.



Lower Keys Medical Center

Historical Operations Analysis | Balance Sheet

Final Report

		LKMC + DePoo			LKMC Only	Common Size Balance Sheet		
Balance Sheet	Footnotes	Dec. 31, 2024	Dec. 31, 2025	Adjustments	Dec. 31, 2025	Dec. 31, 2024	Dec. 31, 2025	Dec. 31, 2025
Liabilities and Shareholders' Equity								
Current Liabilities								
Accounts Payable		1,340,286	2,901,445	-	2,901,445	2.6%	5.0%	5.2%
Accrued Salaries and Benefits		667,034	540,966	-	540,966	1.3%	0.9%	1.0%
Accrued Expenses		2,511,599	2,524,965	-	2,524,965	4.8%	4.4%	4.5%
Current Portion of Long-Term Debt	2	861,861	910,815	(910,815)	-	1.7%	1.6%	-
Accrued Interest	2	143,165	110,207	(110,207)	-	0.3%	0.2%	-
ROU Operating Lease Liability, Short-Term		378,911	348,826	-	348,826	0.7%	0.6%	0.6%
		5,902,856	7,337,224	(1,021,022)	6,316,202	11.4%	12.7%	11.3%
Long-Term Liabilities								
Long-Term Debt	2	2,890,585	1,979,772	(1,979,772)	-	5.6%	3.4%	-
ROU Operating Lease Liability, Long-Term		344,473	755,082	-	755,082	0.7%	1.3%	1.4%
Net Intercompany		(264,008,357)	(295,882,370)	295,882,370	-	(508.8%)	(511.3%)	-
		(260,773,299)	(293,147,516)	293,902,598	755,082	(502.6%)	(506.6%)	1.4%
Equity								
Retained Earnings		306,757,329	343,673,668	-	343,673,668	591.2%	593.9%	617.0%
Illustrative Balance Adjustment		-	-	(295,044,485)	(295,044,485)	-	-	(529.7%)
		306,757,329	343,673,668	(295,044,485)	48,629,183	591.2%	593.9%	87.3%
Total Liabilities and Shareholders' Equity		\$51,886,886	\$57,863,376	(\$2,162,909)	\$55,700,467	100.0%	100.0%	100.0%
Growth		n/a	11.5%		(3.7%)			

Notes and Sources

- (1) Sources: VMG utilized unaudited financials provided by the District for the time periods presented.
- (2) For FY 2024 and 2025, VMG was provided balance sheets specific to the reporting unit "1005", which we understand excludes operations associated with the ASC and ancillary clinics, but includes operations associated with both Lower Keys Medical Center and the DePoo facility. Based on discussions with Hospital management, there is no definitive way to exclude assets and/or liabilities from the "1005" balance sheets. However, VMG understands all interest-bearing debt outstanding is related entirely to the DePoo facility. Therefore, interest-bearing debt has been adjusted out of the December 31, 2025 balance sheet.



Reported Net Working Capital	Footnotes	Dec. 31, 2024	Dec. 31, 2025
Current Assets			
Net Accounts Receivable		35,725,045	34,984,348
Allowance for Uncollectible Accounts		(17,302,097)	(13,124,128)
Prior-Year Settlement		86,567	(233,335)
Inventories		2,641,295	2,969,081
Prepaid Expenses		691,033	414,491
Other Current Assets		101,610	221,511
		<u>\$21,943,453</u>	<u>\$25,231,968</u>
Current Liabilities			
Accounts Payable		\$1,340,286	\$2,901,445
Accrued Salaries and Benefits		667,034	540,966
Accrued Expenses		2,511,599	2,524,965
Current Portion of Long-Term Debt	(2)	-	-
Accrued Interest	(2)	-	-
ROU Operating Lease Liability, Short-Term	(2)	-	-
		<u>\$4,518,919</u>	<u>\$5,967,376</u>
Reported Net Working Capital		\$17,424,534	\$19,264,592
Total Net Operating Revenue		\$116,681,093	\$128,901,650
Reported Net Working Capital as a Percent of Total Net Operating Revenue		14.9%	14.9%

Notes and Sources

(1) Sources: VMG utilized unaudited financials provided by the District for the time periods presented.

(2) Indicates accounts not considered in the calculation of Reported Net Working Capital



Guideline Public Company Net Working Capital Metrics	FY - 2	FY - 1	FYE	TTM
Net Working Capital (As a Percent of Revenues)				
1. HCA Healthcare, Inc.	7.8%	8.9%	6.2%	7.0%
2. Tenet Healthcare Corporation	13.3%	17.7%	17.3%	10.7%
3. Universal Health Services, Inc.	7.0%	4.6%	5.7%	6.1%
4. Community Health Systems, Inc.	9.7%	8.6%	9.2%	10.8%
5. Ardent Health, Inc.	12.7%	15.8%	17.2%	17.2%
Median	9.7%	8.9%	9.2%	10.7%
Average	10.1%	11.1%	11.1%	10.4%
Lower Keys Medical Center	6.1%	9.6%	14.9%	14.9%

Cash-Free Net Working Capital (As a Percent of Revenues)				
1. HCA Healthcare, Inc.	6.2%	6.0%	4.7%	5.6%
2. Tenet Healthcare Corporation	7.3%	3.1%	3.7%	(3.2%)
3. Universal Health Services, Inc.	6.1%	3.8%	4.9%	5.4%
4. Community Health Systems, Inc.	9.4%	8.3%	7.1%	5.0%
5. Ardent Health, Inc.	4.3%	6.3%	6.0%	7.7%
Median	6.2%	6.0%	4.9%	5.4%
Mean	6.7%	5.5%	5.3%	4.1%
Lower Keys Medical Center	6.1%	9.2%	14.9%	14.9%

Notes and Sources

- (1) Source(s): S&P's Capital IQ as of June 16, 2026. Historical financials are "Latest" (i.e., information is retrieved from the most recent period, including press releases). Estimates are consolidated (i.e., includes the parent company and all subsidiaries). Source financials retrieved are as of the company's period end date. Where applicable, the historical spot exchange rate on the period end date is applied to foreign currency types across all historical periods. Unless otherwise noted, data is presented in USD (\$), in thousands.



Lower Keys Medical Center

Historical Operations Analysis | Income Statement

Final Report

Income Statement	LKMC Only		Common Size	
	FY 2024	FY 2025	FY 2024	FY 2025
Net Operating Revenue				
Gross Inpatient Revenue	\$167,667,921	\$182,637,225	143.7%	141.7%
Gross Outpatient Revenue	286,853,805	299,089,400	245.8%	232.0%
Gross Inpatient Adjustments and Refunds	(118,290,417)	(130,045,013)	(101.4%)	(100.9%)
Gross Outpatient Adjustments and Refunds	(201,848,436)	(211,335,302)	(173.0%)	(164.0%)
Net Fee-for-Service Revenue	134,382,873	140,346,310	115.2%	108.9%
Growth	n/a	4.4%		
Bad Debt	(17,395,379)	(12,747,865)	(14.9%)	(9.9%)
Other Operating Revenue	(306,401)	1,303,205	(0.3%)	1.0%
Total Net Operating Revenue	116,681,093	128,901,650	100.0%	100.0%
Growth	n/a	10.5%		
Operating Expenses				
<i>Employee Salaries and Wages</i>				
Salaries and Wages	29,827,370	31,391,503	25.6%	24.4%
Contract Labor	2,188,237	3,242,536	1.9%	2.5%
	32,015,607	34,634,039	27.4%	26.9%
<i>Employee Benefits</i>				
Employee Benefits	6,368,600	7,233,998	5.5%	5.6%
	6,368,600	7,233,998	5.5%	5.6%
<i>Occupancy Costs</i>				
Utilities	1,915,989	2,217,155	1.6%	1.7%
	1,915,989	2,217,155	1.6%	1.7%
<i>Drugs and Medical Supplies</i>				
Medical Supplies	8,779,280	8,977,450	7.5%	7.0%
	8,779,280	8,977,450	7.5%	7.0%
<i>Insurance</i>				
Professional Liability and General Business	3,129,119	4,017,727	2.7%	3.1%
	3,129,119	4,017,727	2.7%	3.1%
<i>General and Administrative</i>				
Purchased Services	11,092,075	14,345,662	9.5%	11.1%
Medical Specialist Fees	4,248,381	5,998,418	3.6%	4.7%
Taxes and Licenses	4,301,580	5,316,835	3.7%	4.1%
Repairs and Maintenance	3,546,602	2,281,064	3.0%	1.8%
Lease and Rent Costs	1,260,488	1,766,896	1.1%	1.4%
Management Fees	2,745,125	1,535,976	2.4%	1.2%
Advertising and Marketing	370,383	641,216	0.3%	0.5%
Other Operating Expenses	271,516	202,502	0.2%	0.2%
Travel, Meals, and Entertainment	90,062	78,818	0.1%	0.1%
Equipment Expense	92,956	73,973	0.1%	0.1%
Physician Recruitment Costs	1,761	2,017	0.0%	0.0%
	28,020,929	32,243,377	24.0%	25.0%
Total Operating Expenses	80,229,524	89,323,746	68.8%	69.3%
Growth	n/a	11.3%		



Income Statement	LKMC Only		Common Size	
	FY 2024	FY 2025	FY 2024	FY 2025
EBITDA	36,451,569	39,577,904	31.2%	30.7%
Growth	n/a	8.6%		
Depreciation and Amortization Expense	6,738,505	7,245,491	5.8%	5.6%
Interest Expense	199,197	165,531	0.2%	0.1%
Earnings Before Non-Operating Items	29,513,867	32,166,882	25.3%	25.0%
Non-Operating Expense (Income)	-	(858,202)	-	(0.7%)
Earnings After Income Taxes	\$29,513,867	\$33,025,084	25.3%	25.6%
Growth	n/a	11.9%		

Notes and Sources

- (1) Sources: VMG utilized unaudited financials provided by the District for the time periods presented.
- (2) FY 2025 = Trailing twelve months January 1, 2025 through December 31, 2025
- (3) For FY 2024 and 2025, VMG was provided income statements specific to the reporting unit "1005", which we understand excludes operations associated with the ASC and ancillary clinics, but includes operations associated with both Lower Keys Medical Center and the DePoo facility. VMG was provided income statements for the "Inpatient Behavioral Health Departments", which we understand relates solely to DePoo facility operations. In order to derive a financial view of Hospital operations only, VMG subtracted the "Inpatient Behavioral Health Departments" income statement line items from the "1005" income statement for FY 2024 and FY 2025.



Historical Operating Summary	LKMC Only		Key Assumptions
	FY 2024	FY 2025	
Total Inpatient Gross Revenue	\$167,667,921	\$182,637,225	
Total Inpatient Adjustments and Refunds	(\$118,290,417)	(\$130,045,013)	
Total Inpatient Net Revenue	\$49,377,504	\$52,592,212	
Growth	n/a	6.5%	
Total Outpatient Gross Revenue	\$286,853,805	\$299,089,400	
Total Outpatient Adjustments and Refunds	(\$201,848,436)	(\$211,335,302)	
Total Outpatient Net Revenue	\$85,005,369	\$87,754,098	
Growth	n/a	3.2%	
Uncollectible Inpatient Revenue	(\$7,072,512)	(\$3,973,605)	
Uncollectible Outpatient Revenue	(\$10,322,867)	(\$8,774,260)	
Total Net Patient Revenue	\$116,987,494	\$127,598,445	
Growth	n/a	9.1%	
Non-Patient Revenue	(\$306,401)	\$1,303,205	
Total Net Operating Revenue	\$116,681,093	\$128,901,650	
Growth	n/a	10.5%	

Notes and Sources

(1) Source(s): We have utilized the income statements and the files titled "E.1 Stats" and "LOKY D26 Rev & Admits by Payor 2023-2025" provided by Hospital management for the time periods presented.



		LKMC Only		Key Assumptions
Historical Operating Summary		FY 2024	FY 2025	
Inpatient Statistics				
Total Acute Inpatient Admissions		2,385	2,399	Notes and Sources (2)
Growth		n/a	0.6%	
Net Inpatient Revenue per Admission		\$20,703	\$21,923	
Growth		n/a	5.9%	
Total Acute Patient Days		8,779	8,420	Notes and Sources (2)
Growth		n/a	(4.1%)	
Net Inpatient Revenue per Patient Day		\$5,625	\$6,246	
Growth		n/a	11.1%	
Average Daily Census ("ADC")		24.1	23.1	
Percent Occupancy		24.3%	23.3%	
Average Length of Stay ("ALOS")		3.7	3.5	
Total Surgeries		2,759	2,114	Notes and Sources (2)
Growth		n/a	(23.4%)	
Total Deliveries		483	418	Notes and Sources (2)
Growth		n/a	(13.5%)	

Notes and Sources

(1) Sources: We have utilized the income statements and the files titled "E.1 Stats" and "LOKY D26 Rev & Admits by Payor 2023-2025" provided by Hospital management for the time periods presented.



Historical Operating Summary	LKMC Only		Key Assumptions
	FY 2024	FY 2025	
Outpatient Statistics			
Total Outpatient Visits	49,968	50,402	Notes and Sources (2)
Growth	n/a	0.9%	
Net Outpatient Revenue per Visit	\$1,701	\$1,741	
Growth	n/a	2.3%	
Total ER Visits	23,324	22,312	
Growth	n/a	(4.3%)	
Total ER Admits	2,097	2,150	Notes and Sources (2)
Growth	n/a	2.5%	
Total Statistics			
Adjusted Admissions	6,465	6,328	
Growth	n/a	(2.1%)	
Adjusted Patient Days	23,799	22,209	
Growth	n/a	(6.7%)	
Total Net Revenue per Adjusted Admission	\$20,785	\$22,180	
Growth	n/a	6.7%	
Total Net Revenue per Adjusted Patient Day	\$5,647	\$6,319	
Growth	n/a	11.9%	

Notes and Sources

- (1) Sources: We have utilized the income statements and the files titled "E.1 Stats" and "LOKY D26 Rev & Admits by Payor 2023-2025" provided by Hospital management for the time periods presented.
- (2) Please note, VMG has assumed that ER Admits represented in the file titled "E.1 Stats" include admits associated with the DePoo facility, as we were not provided with the breakout.



Lower Keys Medical Center

Historical Operations Analysis | Inpatient Payor Mix Analysis

Final Report

Historical Metrics by Payor	Admissions		Gross Charges		Collections	
	FY 2024	FY 2025	FY 2024	FY 2025	FY 2024	FY 2025
1. Medicare	716	758	\$58,522,576	\$64,295,358	\$11,834,570	\$12,401,939
2. Medicaid	270	229	19,633,856	16,010,803	7,466,718	8,528,574
3. Medicare Managed Care	224	292	16,540,010	24,464,936	3,196,599	4,075,810
4. Health Exchange	-	8	-	412,604	-	178,038
5. Commercial	746	745	46,346,972	52,653,138	19,347,524	22,338,559
6. Self-Pay	236	169	15,438,247	13,407,524	5,063,321	2,172,873
7. Other Government	177	189	10,081,992	10,532,035	2,358,797	2,635,009
8. Other	16	9	1,104,268	860,827	109,976	261,408
Total	2,385	2,399	\$167,667,921	\$182,637,225	\$49,377,504	\$52,592,212

As a Percent of Total	Admission Volume as a Percent of Total Volume		Gross Charges as a Percent of Total Gross Charges		Collections as a Percent of Total Collections	
	FY 2024	FY 2025	FY 2024	FY 2025	FY 2024	FY 2025
1. Medicare	30.0%	31.6%	34.9%	35.2%	24.0%	23.6%
2. Medicaid	11.3%	9.5%	11.7%	8.8%	15.1%	16.2%
3. Medicare Managed Care	9.4%	12.2%	9.9%	13.4%	6.5%	7.7%
4. Health Exchange	-	0.3%	-	0.2%	-	0.3%
5. Commercial	31.3%	31.1%	27.6%	28.8%	39.2%	42.5%
6. Self-Pay	9.9%	7.0%	9.2%	7.3%	10.3%	4.1%
7. Other Government	7.4%	7.9%	6.0%	5.8%	4.8%	5.0%
8. Other	0.7%	0.4%	0.7%	0.5%	0.2%	0.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Additional Metrics by Payor	Collections per Admission		Collections as a Percent of Gross Charges		Implied % of Medicare Based on Relative Charges to Collections Ratio	
	FY 2024	FY 2025	FY 2024	FY 2025	FY 2024	FY 2025
1. Medicare	\$16,529	\$16,361	20.2%	19.3%	100.0%	100.0%
2. Medicaid	\$27,655	\$37,243	38.0%	53.3%	188.1%	276.2%
3. Medicare Managed Care	\$14,271	\$13,958	19.3%	16.7%	95.6%	86.4%
4. Health Exchange	n/a	\$22,255	n/a	43.1%	n/a	223.7%
5. Commercial	\$25,935	\$29,985	41.7%	42.4%	206.4%	219.9%
6. Self-Pay	\$21,455	\$12,857	32.8%	16.2%	162.2%	84.0%
7. Other Government	\$13,327	\$13,942	23.4%	25.0%	115.7%	129.7%
8. Other	\$6,873	\$29,045	10.0%	30.4%	49.2%	157.4%
Total	\$20,703	\$21,923	29.4%	28.8%	145.6%	149.3%

Notes and Sources

- (1) Sources: We have utilized the files titled "LOKY D26 Rev & Admits by Payor 2023-2025" provided by Hospital management for the time periods presented.
- (2) Please note, this data as presented above is representative of the production data provided by Management. A weighted average has been applied to reconcile the provided production data to the Net-Fee-for-Service on the Income Statement.



Lower Keys Medical Center

Historical Operations Analysis | Outpatient Payor Mix Analysis

Historical Metrics by Payor	Visits		Gross Charges		Collections	
	FY 2024	FY 2025	FY 2024	FY 2025	FY 2024	FY 2025
1. Medicare	12,651	12,540	\$73,080,540	\$78,818,312	\$6,302,847	\$6,826,035
2. Medicaid	5,823	5,349	19,335,506	17,784,166	1,674,881	1,471,236
3. Medicare Managed Care	4,095	4,199	27,664,818	30,465,549	2,731,456	2,794,993
4. Health Exchange	-	254	-	1,234,092	-	370,962
5. Commercial	17,017	17,620	106,728,422	109,424,726	63,095,148	66,625,222
6. Self-Pay	5,003	4,058	28,063,068	24,164,929	7,306,516	4,833,619
7. Other Government	-	-	-	-	-	-
8. Other	849	879	7,715,928	7,530,149	1,817,640	2,098,786
Total	45,438	44,899	\$262,588,282	\$269,421,923	\$82,928,488	\$85,020,854

As a Percent of Total	Visit Volume as a Percent of Total Volume		Gross Charges as a Percent of Total Gross Charges		Collections as a Percent of Total Collections	
	FY 2024	FY 2025	FY 2024	FY 2025	FY 2024	FY 2025
1. Medicare	27.8%	27.9%	27.8%	29.3%	7.6%	8.0%
2. Medicaid	12.8%	11.9%	7.4%	6.6%	2.0%	1.7%
3. Medicare Managed Care	9.0%	9.4%	10.5%	11.3%	3.3%	3.3%
4. Health Exchange	-	0.6%	-	0.5%	-	0.4%
5. Commercial	37.5%	39.2%	40.6%	40.6%	76.1%	78.4%
6. Self-Pay	11.0%	9.0%	10.7%	9.0%	8.8%	5.7%
7. Other Government	-	-	-	-	-	-
8. Other	1.9%	2.0%	2.9%	2.8%	2.2%	2.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Additional Metrics by Payor	Collections per Visit		Collections as a Percent of Gross Charges		Implied % of Medicare Based on Relative Charges to Collections Ratio	
	FY 2024	FY 2025	FY 2024	FY 2025	FY 2024	FY 2025
1. Medicare	\$498	\$544	8.6%	8.7%	100.0%	100.0%
2. Medicaid	\$288	\$275	8.7%	8.3%	100.4%	95.5%
3. Medicare Managed Care	\$667	\$666	9.9%	9.2%	114.5%	105.9%
4. Health Exchange	n/a	\$1,460	n/a	30.1%	n/a	347.1%
5. Commercial	\$3,708	\$3,781	59.1%	60.9%	685.5%	703.0%
6. Self-Pay	\$1,460	\$1,191	26.0%	20.0%	301.9%	231.0%
7. Other Government	n/a	n/a	n/a	n/a	n/a	n/a
8. Other	\$2,141	\$2,388	23.6%	27.9%	273.1%	321.8%
Total	\$1,825	\$1,894	31.6%	31.6%	366.2%	364.4%

Notes and Sources

- (1) Sources: We have utilized the files titled "LOKY D26 Rev & Admits by Payor 2023-2025" provided by Hospital management for the time periods presented.
- (2) Please note, this data as presented above is representative of the production data provided by Management. A weighted average has been applied to reconcile the provided production data to the Net-Fee-for-Service on the Income Statement.



Specialty	Active Providers
1. Anesthesiology	4
2. Cardiovascular Disease	5
3. Emergency Medicine	7
4. Family Medicine	1
5. Foot and Ankle Surgery	1
6. Gastroenterology	2
7. Gynecology	1
8. Infectious Disease	1
9. Internal Medicine	7
10. Interventional Cardiology	4
11. Interventional Radiology and Diagnostic Radiology	1
12. Nephrology	1
13. Neurology	1
14. Obstetrics & Gynecology	5
15. Ophthalmology	2
16. Oral and Maxillofacial Surgery	1
17. Orthopedic Surgery	4
18. Orthopedic Surgery- Spine	1
19. Orthopedic Surgery- Trauma Surgery	2
20. Otolaryngology	1
21. Pain Medicine	1
22. Pathology-Clinical	2
23. Pediatrics	2
24. Plastic & Reconstructive Surgery	1
25. Podiatric Medicine and Surgery	2
26. Psychiatry	2
27. Radiology - Diagnostic Radiology	2
28. Surgery - General	4
29. Telemedicine-Radiology	1
30. Urology	1
Total	70

Allied Health Professionals	Active Providers
1. APRN	9
2. Certified Nurse Midwife	2
3. Certified Registered Nurse Anesthetist	3
4. Emergency Medicine	2
5. Family Nurse Practitioner	2
6. Licensed Clinical Social Worker	1
7. Neurology PA	3
8. Physician Assistant	1
9. Physician Assistant Ortho	1
10. Psychiatry NP	2
11. Registered Nurse First Assistant	2
Total	28

Notes and Sources

(1) Source(s): "F.1 LKMC Med Staff Feb 10 2026" provided by the District



Final Report

Lower Keys Medical Center

Income Approach

Strictly Private and Confidential

Lower Keys Medical Center

Income Approach | Development of the Normalized Base Year

Final Report

					Common Size		Historical and Normalized Statistics Analysis		
Income Statement	Footnotes	FY 2025	Adjustments	NBY	FY 2025	NBY	Selected Statistics	FY 2025	NBY
Net Operating Revenue									
Gross Inpatient Revenue		\$182,637,225	-	\$182,637,225	141.7%	146.2%	per Inpatient Admission	\$76,131	\$76,131
Gross Outpatient Revenue		299,089,400	-	299,089,400	232.0%	239.4%	per Outpatient Visit	\$5,934	\$5,934
Gross Inpatient Adjustments and Refunds		(130,045,013)	-	(130,045,013)	(100.9%)	(104.1%)	per Inpatient Admission	(\$54,208)	(\$54,208)
Gross Outpatient Adjustments and Refunds		(211,335,302)	-	(211,335,302)	(164.0%)	(169.2%)	per Outpatient Visit	(\$4,193)	(\$4,193)
Total Net Fee-for-Service Revenue		140,346,310	-	140,346,310	108.9%	112.3%	per Adjusted Patient Day	\$6,319	\$6,319
Bad Debt	1	(12,747,865)	(2,690,229)	(15,438,094)	(9.9%)	(12.4%)	per Adjusted Patient Day	(\$574)	(\$695)
Other Operating Revenue	2	1,303,205	(1,288,205)	15,000	1.0%	0.0%	per Adjusted Patient Day	\$59	\$1
Total Net Operating Revenue		128,901,650	(3,978,434)	124,923,216	100.0%	100.0%	per Adjusted Patient Day	\$5,804	\$5,625
Growth		n/a							
Operating Expenses									
Employee Salaries and Wages									
Salaries and Wages		31,391,503	-	31,391,503	24.4%	25.1%	per Adjusted Patient Day	\$1,413	\$1,413
Contract Labor		3,242,536	-	3,242,536	2.5%	2.6%	per Adjusted Patient Day	\$146	\$146
		34,634,039	-	34,634,039	26.9%	27.7%	per Adjusted Patient Day	\$1,559	\$1,559
Employee Benefits									
Employee Benefits		7,233,998	-	7,233,998	5.6%	5.8%	% of Salaries and Wages	23.0%	23.0%
		7,233,998	-	7,233,998	5.6%	5.8%	% of Salaries and Wages	23.0%	23.0%
Occupancy Costs									
Utilities		2,217,155	-	2,217,155	1.7%	1.8%	per Square Foot	\$23.34	\$23.34
		2,217,155	-	2,217,155	1.7%	1.8%	per Adjusted Patient Day	\$99.83	\$99.83
Drugs and Medical Supplies									
Medical Supplies		8,977,450	-	8,977,450	7.0%	7.2%	per Adjusted Patient Day	\$404	\$404
		8,977,450	-	8,977,450	7.0%	7.2%	per Adjusted Patient Day	\$404	\$404
Insurance									
Professional Liability and General Business		4,017,727	-	4,017,727	3.1%	3.2%	per Adjusted Patient Day	\$181	\$181
		4,017,727	-	4,017,727	3.1%	3.2%	per Adjusted Patient Day	\$181	\$181



Lower Keys Medical Center

Income Approach | Development of the Normalized Base Year

Final Report

					Common Size		Historical and Normalized Statistics Analysis		
Income Statement	Footnotes	FY 2025	Adjustments	NBY	FY 2025	NBY	Selected Statistics	FY 2025	NBY
General and Administrative									
Purchased Services		14,345,662	-	14,345,662	11.1%	11.5%	per Adjusted Patient Day	\$646	\$646
Medical Specialist Fees		5,998,418	-	5,998,418	4.7%	4.8%	per Adjusted Patient Day	\$270	\$270
Taxes and Licenses		5,316,835	-	5,316,835	4.1%	4.3%	per Adjusted Patient Day	\$239	\$239
Repairs and Maintenance		2,281,064	-	2,281,064	1.8%	1.8%	per Adjusted Patient Day	\$103	\$103
Lease and Rent Costs		1,766,896	-	1,766,896	1.4%	1.4%	per Adjusted Patient Day	\$80	\$80
Management Fees		1,535,976	-	1,535,976	1.2%	1.2%	per Adjusted Patient Day	\$69	\$69
Advertising and Marketing		641,216	-	641,216	0.5%	0.5%	per Adjusted Patient Day	\$29	\$29
Other Operating Expenses		202,502	-	202,502	0.2%	0.2%	per Adjusted Patient Day	\$9	\$9
Travel, Meals, and Entertainment		78,818	-	78,818	0.1%	0.1%	per Adjusted Patient Day	\$4	\$4
Equipment Expense		73,973	-	73,973	0.1%	0.1%	per Adjusted Patient Day	\$3	\$3
Physician Recruitment Costs		2,017	-	2,017	0.0%	0.0%	per Adjusted Patient Day	\$0	\$0
		32,243,377	-	32,243,377	25.0%	25.8%	per Adjusted Patient Day	\$1,452	\$1,452
Total Operating Expenses		89,323,746	-	89,323,746	69.3%	71.5%	per Adjusted Patient Day	\$4,022	\$4,022
Growth		n/a							
EBITDA		39,577,904	(3,978,434)	35,599,470	30.7%	28.5%	per Adjusted Patient Day	\$1,782	\$1,603
Growth		n/a							
Depreciation and Amortization Expense		7,245,491	-	7,245,491	5.6%	5.8%	per Adjusted Patient Day	\$326	\$326
Interest Expense	3	165,531	(165,531)	-	0.1%	-	per Adjusted Patient Day	\$7	-
Earnings Before Non-Operating Items		32,166,882	(3,812,903)	28,353,979	25.0%	22.7%	per Adjusted Patient Day	\$1,448	\$1,277
Non-Operating Expense (Income)	4	(858,202)	858,202	-	(0.7%)	-	per Adjusted Patient Day	(\$39)	-
Earnings Before Income Taxes		33,025,084	(4,671,105)	28,353,979	25.6%	22.7%	per Adjusted Patient Day	\$1,487	\$1,277
Federal and State Income Tax Expense	5	-	7,186,316	7,186,316	-	5.8%	per Adjusted Patient Day	-	\$324
Earnings After Income Taxes		\$33,025,084	(\$11,857,421)	\$21,167,663	25.6%	16.9%	per Adjusted Patient Day	\$1,487	\$953
Growth		n/a							

Notes and Sources

The Normalized Base Year ("NBY") is based on the FY 2025 income statement. Nonrecurring and nonoperational items are adjusted out of the FY 2025 income statement to give a clearer, more accurate picture of the Hospital's operations from which to project the income statement in Year 1. Please refer to the following page for details related to each adjustment.



1. Based on discussions with Hospital management, Bad Debt is typically between 10.0% and 12.0% of net fee-for-service revenue. As result, VMG has normalized Bad Debt to the midpoint of this range, or 11.0% of net fee-for-service revenue, accordingly.
2. Based on discussions with management, Other Operating Revenue was elevated in FY 2025 due to the result of a class action lawsuit. According to management, Other Operating Revenue is typically \$15,000 annually. As a result, VMG has normalized this expense accordingly in the NBY.
3. Interest Expense was eliminated to derive debt-free cash flows.
4. Non-Operating Expense (Income) has been eliminated to project only recurring patient-service revenues.
5. Our analysis has applied a blended federal and state income tax rate of 25.35% to the earnings before taxes. Discount rates used in the valuation are market based and derived in part from the publicly traded comparable companies. These companies are for profit; thus, the market-based discount rate is an after-tax discount rate. Therefore, NBY earnings of the Hospital are tax affected using a blended federal and state tax rate to match the expected future cash flows with the level of cash flow stream being discounted.



Lower Keys Medical Center

Income Approach | Revenue Assumptions

	LKMC Only			Projection Period					
Total Net Operating Revenue	FY 2024	FY 2025	NBY	Year 1	Year 2	Year 3	Year 4	Year 5	Key Assumptions
Inpatient									
Estimated Admissions per Year	2,385	2,399	2,399	2,375	2,351	2,328	2,304	2,281	
Growth	n/a	0.6%	-	(1.0%)	(1.0%)	(1.0%)	(1.0%)	(1.0%)	
Estimated Patient Days	8,779	8,420	8,420	8,336	8,252	8,170	8,088	8,007	
Growth	(3.8%)	(4.1%)	-	(1.0%)	(1.0%)	(1.0%)	(1.0%)	(1.0%)	See Footnote (1)
Average Daily Census	24.1	23.1	23.1	22.8	22.6	22.4	22.2	21.9	
Average Length of Stay	3.7	3.5	3.5	3.5	3.5	3.5	3.5	3.5	
Estimated Gross Charges per Patient Day	\$19,099	\$21,691	\$21,691	\$22,342	\$23,012	\$23,702	\$24,413	\$25,146	
Growth	(15.6%)	13.6%	-	3.0%	3.0%	3.0%	3.0%	3.0%	3.0% year-over-year growth
Less: Inpatient Adjustments and Refunds	(\$13,474)	(\$15,445)	(\$15,445)	(\$15,955)	(\$16,489)	(\$17,052)	(\$17,633)	(\$18,233)	
As a Percent of Gross Charges	(70.6%)	(71.2%)	(71.2%)	(71.4%)	(71.7%)	(71.9%)	(72.2%)	(72.5%)	
Estimated Net Fee-for-Service Revenue per Patient Day	\$5,625	\$6,246	\$6,246	\$6,386	\$6,523	\$6,651	\$6,781	\$6,913	Refer to the Inpatient Reimbursement
Growth	(6.4%)	11.1%	-	2.2%	2.1%	2.0%	2.0%	2.0%	Effect Build-Up Analysis
Inpatient Net Fee-for-Service Revenue	\$49,377,504	\$52,592,212	\$52,592,212	\$53,234,550	\$53,833,507	\$54,335,600	\$54,842,375	\$55,353,877	
Growth	n/a	6.5%	-	1.2%	1.1%	0.9%	0.9%	0.9%	
Outpatient									
Estimated Visits per Year	49,968	50,402	50,402	51,662	52,954	54,277	55,634	57,025	
Growth	(50.7%)	0.9%	-	2.5%	2.5%	2.5%	2.5%	2.5%	See Footnote (2)
Estimated Gross Charges per Visit	\$5,741	\$5,934	\$5,934	\$6,112	\$6,295	\$6,484	\$6,679	\$6,879	
Growth	80.0%	3.4%	-	3.0%	3.0%	3.0%	3.0%	3.0%	3.0% year-over-year growth
Less: Outpatient Adjustments and Refunds	(\$4,040)	(\$4,193)	(\$4,193)	(\$4,331)	(\$4,479)	(\$4,631)	(\$4,788)	(\$4,950)	
As a Percent of Gross Charges	(70.4%)	(70.7%)	(70.7%)	(70.9%)	(71.1%)	(71.4%)	(71.7%)	(71.9%)	
Estimated Net Fee-for-Service Revenue per Visit	\$1,701	\$1,741	\$1,741	\$1,781	\$1,817	\$1,854	\$1,891	\$1,930	Refer to the Outpatient Reimbursement
Growth	86.7%	2.3%	-	2.3%	2.0%	2.0%	2.0%	2.0%	Effect Build-Up Analysis
Outpatient Net Fee-for-Service Revenue	\$85,005,369	\$87,754,098	\$87,754,098	\$91,992,521	\$96,206,173	\$100,612,827	\$105,221,326	\$110,040,913	
Growth	n/a	3.2%	-	4.8%	4.6%	4.6%	4.6%	4.6%	

Notes and Sources

- (1) Based on representations in the file titled "Draft RFP LFKHD CLEAN DRAFT 6.2.26.docx" provided by District, inpatient volumes across all service lines within LKMC's primary service area ("PSA"), which represents zip codes 33040, 33042, and 33043, are projected to decline by approximately 6.0% over the next five years, which aligns with trends in broader national patterns in care shifting from inpatient to outpatient settings. As a result, VMG has assumed that LKMC's inpatient volumes will trend in line with its peers.
- (2) Based on representations in the file titled "Draft RFP LFKHD CLEAN DRAFT 6.2.26.docx" provided by District, LKMC's PSA is expected to increase in population by approximately 1.4% over the next five years, and outpatient volumes are expected to grow by 12.3% over the next five years.



	LKMC Only			Projection Period					Key Assumptions
Total Net Operating Revenue	FY 2024	FY 2025	NBY	Year 1	Year 2	Year 3	Year 4	Year 5	
Total Net Operating Revenue									
Gross Inpatient Revenue	\$167,667,921	\$182,637,225	\$182,637,225	\$186,235,178	\$189,904,011	\$193,645,120	\$197,459,929	\$201,349,890	
Gross Outpatient Revenue	\$286,853,805	\$299,089,400	\$299,089,400	\$315,763,634	\$333,367,457	\$351,952,692	\$371,574,055	\$392,289,309	
Gross Charges Growth	(18.8%)	8.9%	-	4.2%	4.2%	4.3%	4.3%	4.3%	
Gross Inpatient Adjustments and Refunds	(118,290,417)	(130,045,013)	(130,045,013)	(133,000,628)	(136,070,504)	(139,309,521)	(142,617,554)	(145,996,013)	
Gross Outpatient Adjustments and Refunds	(201,848,436)	(211,335,302)	(211,335,302)	(223,771,113)	(237,161,284)	(251,339,865)	(266,352,729)	(282,248,396)	
Net Fee-for-Service Revenue	134,382,873	140,346,310	140,346,310	145,227,071	150,039,680	154,948,427	160,063,701	165,394,790	
Growth	n/a	4.4%	-	3.5%	3.3%	3.3%	3.3%	3.3%	
Bad Debt	(17,395,379)	(12,747,865)	(15,438,094)	(15,974,978)	(16,504,365)	(17,044,327)	(17,607,007)	(18,193,427)	Percent of Net Fee-for-Service Revenue
Other Operating Revenue	(306,401)	1,303,205	15,000	15,450	15,914	16,391	16,883	17,389	Increase with Inflation
Total Net Operating Revenue	\$116,681,093	\$128,901,650	\$124,923,216	\$129,267,544	\$133,551,229	\$137,920,491	\$142,473,576	\$147,218,752	
Growth	n/a	10.5%	(3.1%)	3.5%	3.3%	3.3%	3.3%	3.3%	
Key Revenue Statistics									
Total Adjusted Admissions	6,465	6,328	6,328	6,402	6,479	6,558	6,641	6,726	
Growth	n/a	(2.1%)	-	1.2%	1.2%	1.2%	1.3%	1.3%	
Total Adjusted Patient Days	23,799	22,209	22,209	22,469	22,739	23,019	23,308	23,608	
Growth	n/a	(6.7%)	-	1.2%	1.2%	1.2%	1.3%	1.3%	
Weeks Worked per Year	52	52	52	52	52	52	52	52	
Days Worked per Year	260	260	260	260	260	260	260	260	
Average Adjusted Admissions per Week	124.3	121.7	121.7	123.1	124.6	126.1	127.7	129.4	
Average Adjusted Admissions per Day	24.9	24.3	24.3	24.6	24.9	25.2	25.5	25.9	
Estimated Net Fee-for-Service Revenue per Adjusted Patient Day	\$5,647	\$6,319	\$6,319	\$6,463	\$6,598	\$6,731	\$6,867	\$7,006	
Growth	n/a	11.9%	-	2.3%	2.1%	2.0%	2.0%	2.0%	



Inpatient Reimbursement Effect Build-Up Analysis	Medicare	Medicaid	Medicare Managed Care	Health Exchange	Commercial	Self-Pay	Other Government	Other	Aggregate Effect
All Types	35.2%	8.8%	13.4%	0.2%	28.8%	7.3%	5.8%	0.5%	100.0%
Year 1	2.6%	-	2.6%	-	3.0%	-	2.0%	-	2.2%
Year 2	2.4%	-	2.4%	-	3.0%	-	2.0%	-	2.1%
Year 3	2.0%	-	2.0%	-	3.0%	-	2.0%	-	2.0%
Year 4	2.0%	-	2.0%	-	3.0%	-	2.0%	-	2.0%
Year 5	2.0%	-	2.0%	-	3.0%	-	2.0%	-	2.0%

Notes and Sources

- (1) Medicare Year 1 reimbursement increase is based on The Center for Medicare & Medicaid Services ("CMS") Final FY 2026 Medicare Hospital Inpatient Prospective Payment System ("IPPS") Rule. The final rule will increase payments to acute care hospitals overall by 2.6% from FY 2025 based on a hospital market basket increase of 3.3% and a 0.7% reduction for total factor productivity.
- (2) Medicare Year 2 reimbursement increase is based on The Center for Medicare & Medicaid Services ("CMS") Proposed FY 2027 Medicare Hospital Inpatient Prospective Payment System ("IPPS") Rule. The proposed rule will increase payments to acute care hospitals overall by 2.4% from FY 2026 based on a hospital market basket increase of 3.2% and a 0.8% reduction for total factor productivity.



Outpatient Reimbursement Effect Build-Up Analysis	Medicare	Medicaid	Medicare Managed Care	Health Exchange	Commercial	Self-Pay	Other Government	Other	Aggregate Effect
All Types	29.3%	6.6%	11.3%	0.5%	40.6%	9.0%	-	2.8%	100.0%
Year 1	2.6%	-	2.6%	-	3.0%	-	2.0%	-	2.3%
Year 2	2.0%	-	2.0%	-	3.0%	-	2.0%	-	2.0%
Year 3	2.0%	-	2.0%	-	3.0%	-	2.0%	-	2.0%
Year 4	2.0%	-	2.0%	-	3.0%	-	2.0%	-	2.0%
Year 5	2.0%	-	2.0%	-	3.0%	-	2.0%	-	2.0%

Notes and Sources

(1) Medicare Year 1 reimbursement increase is based on The Center for Medicare & Medicaid Services ("CMS") Final FY 2026 Hospital Outpatient Prospective Payment ("OPPS") and Ambulatory Surgical Center ("ASC") Payment Systems Rule. The rule will increase payments to hospital outpatient departments and ASCs overall by 2.6% from FY 2025 based on a hospital market basket increase of 3.3% and a 0.7% reduction for total factor productivity.



				Projection Period					Key Assumptions
Operating Expenses	FY 2024	FY 2025	NBY	Year 1	Year 2	Year 3	Year 4	Year 5	
Employee Salaries and Wages									
Total Adjusted Patient Days	23,799	22,209	22,209	22,469	22,739	23,019	23,308	23,608	
Employee Salaries and Wages Summary									
Full-Time Equivalent Employees		435.0	435.0	440.1	445.4	450.9	456.6	462.4	Adjusted with Total Adjusted Patient Days
Average Salary per Full-Time Equivalent		\$72,159	\$72,159	\$74,324	\$76,554	\$78,851	\$81,216	\$83,653	
Growth		n/a	-	3.0%	3.0%	3.0%	3.0%	3.0%	Increase with Inflation
Total Salaries and Wages	\$29,827,370	\$31,391,503	\$31,391,503	\$32,712,531	\$34,098,754	\$35,553,641	\$37,080,849	\$38,684,236	
Growth	n/a	5.2%	-	4.2%	4.2%	4.3%	4.3%	4.3%	
Drugs and Medical Supplies									
Medical Supplies									
Total Adjusted Patient Days	23,799	22,209	22,209	22,469	22,739	23,019	23,308	23,608	
Medical Supplies per Adjusted Patient Day	\$368.90	\$404.23	\$404.23	\$416.36	\$428.85	\$441.71	\$454.97	\$468.61	Increase with Inflation
Growth	n/a	9.6%	-	3.0%	3.0%	3.0%	3.0%	3.0%	
Total Medical Supplies	\$8,779,280	\$8,977,450	\$8,977,450	\$9,355,242	\$9,751,679	\$10,167,752	\$10,604,509	\$11,063,051	
Total Drugs and Medical Supplies									
Growth	n/a	2.3%	-	4.2%	4.2%	4.3%	4.3%	4.3%	



Lower Keys Medical Center

Income Approach | Operating Expense Assumptions

				Projection Period					Key Assumptions
Operating Expenses	FY 2024	FY 2025	NBY	Year 1	Year 2	Year 3	Year 4	Year 5	
Operating Expenses									
Employee Salaries and Wages									
Salaries and Wages	\$29,827,370	\$31,391,503	\$31,391,503	\$32,712,531	\$34,098,754	\$35,553,641	\$37,080,849	\$38,684,236	See Employee Salaries and Wages Assumptions
Contract Labor	2,188,237	3,242,536	3,242,536	3,378,990	3,522,177	3,672,457	3,830,208	3,995,827	Per Adjusted Patient Day / Inflation
Employee Benefits									
Employee Benefits	6,368,600	7,233,998	7,233,998	7,538,422	7,857,869	8,193,140	8,545,076	8,914,568	Remains at 23.0% of Salaries and Wages
Occupancy Costs									
Utilities	1,915,989	2,217,155	2,217,155	2,283,670	2,352,180	2,422,745	2,495,427	2,570,290	Increase with Inflation
Drugs and Medical Supplies									
Medical Supplies	8,779,280	8,977,450	8,977,450	9,355,242	9,751,679	10,167,752	10,604,509	11,063,051	See Drugs and Medical Supplies Assumptions
Insurance									
Professional Liability and General Business	3,129,119	4,017,727	4,017,727	4,138,259	4,262,407	4,390,279	4,521,987	4,657,647	Increase with Inflation
General and Administrative									
Purchased Services	11,092,075	14,345,662	14,345,662	14,949,361	15,582,854	16,247,725	16,945,647	17,678,382	Per Adjusted Patient Day / Inflation
Medical Specialist Fees	4,248,381	5,998,418	5,998,418	6,250,846	6,515,731	6,793,736	7,085,562	7,391,944	Per Adjusted Patient Day / Inflation
Taxes and Licenses	4,301,580	5,316,835	5,316,835	5,501,733	5,684,050	5,870,010	6,063,793	6,265,751	As a Percent of Total Net Operating Revenue
Repairs and Maintenance	3,546,602	2,281,064	2,281,064	2,349,496	2,419,981	2,492,580	2,567,358	2,644,378	Increase with Inflation
Lease and Rent Costs	1,260,488	1,766,896	1,766,896	1,819,903	1,874,500	1,930,735	1,988,657	2,048,317	Increase with Inflation
Management Fees	2,745,125	1,535,976	1,535,976	1,589,391	1,642,061	1,695,782	1,751,764	1,810,108	As a Percent of Total Net Operating Revenue
Advertising and Marketing	370,383	641,216	641,216	660,452	680,266	700,674	721,694	743,345	Increase with Inflation
Other Operating Expenses	271,516	202,502	202,502	208,577	214,834	221,279	227,918	234,755	Increase with Inflation
Travel, Meals, and Entertainment	90,062	78,818	78,818	81,183	83,618	86,127	88,710	91,372	Increase with Inflation
Equipment Expense	92,956	73,973	73,973	76,192	78,478	80,832	83,257	85,755	Increase with Inflation
Physician Recruitment Costs	1,761	2,017	2,017	2,078	2,140	2,204	2,270	2,338	Increase with Inflation
Total Operating Expenses	\$80,229,524	\$89,323,746	\$89,323,746	\$92,896,324	\$96,623,579	\$100,521,699	\$104,604,686	\$108,882,065	
Growth	n/a	11.3%	-	4.0%	4.0%	4.0%	4.1%	4.1%	
Total Operating Expenses per Adj. Patient Day	\$3,371	\$4,022	\$4,022	\$4,134	\$4,249	\$4,367	\$4,488	\$4,612	
Growth	n/a	19.3%	-	2.8%	2.8%	2.8%	2.8%	2.8%	



Discounted Cash Flow Analysis Assumptions	
• Discount Rate	13.0%
• Normalized Net Working Capital	\$6,792,863
• Normalized Net Working Capital as a Percent of Total Net Operating Revenue	5.4%
• Selected Incremental Net Working Capital Requirement as a Percent of Total Net Operating Revenue	5.4%
• Terminal Growth Rate	2.0%
• Blended Federal and State (FL) Corporate Income Tax Rate	25.3%

Depreciation Assumptions	
• Net Initial Basis of Depreciable Fixed Assets	\$26,360,928

Projected Capital Expenditures	Year 1	Year 2	Year 3	Year 4	Year 5	Terminal Year
Total Net Operating Revenue	\$129,267,544	\$133,551,229	\$137,920,491	\$142,473,576	\$147,218,752	\$150,163,127
EBITDA	\$36,371,219	\$36,927,650	\$37,398,792	\$37,868,891	\$38,336,687	\$39,103,421
Total Capital Expenditures	\$4,524,364	\$4,674,293	\$4,827,217	\$4,986,575	\$5,152,656	\$5,255,709
As a Percent of Total Net Operating Revenue	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
As a Percent of EBITDA	12.4%	12.7%	12.9%	13.2%	13.4%	13.4%

Projected Depreciation and Amortization Expense	Year 1	Year 2	Year 3	Year 4	Year 5	Terminal Year
IRC Section 179 Expense	-	\$2,636,800	\$2,715,904	\$2,797,381	\$2,881,303	
IRC Section 168(k) Expense (Bonus Depreciation)	\$20,098,558	\$404,989	\$425,400	\$447,625	\$471,781	
Total Depreciation and Amortization Expense	\$20,795,819	\$3,813,179	\$3,955,295	\$4,102,998	\$4,256,537	\$5,255,709

Notes and Sources

- (1) Projected Depreciation and Amortization Expense was modeled by calendar year, assuming a hypothetical control transaction using an asset deal structure. VMG assumed a hypothetical buyer would follow the guidelines established by IRS Publication 946, How to Depreciate Property (i.e., the Modified Accelerated Cost Recovery System ("MACRS") depreciation), including the application of Section 179 Deductions and Section 168(k) Expenses (i.e., the "Special Depreciation Allowance" or "Bonus Depreciation"), where applicable. The One Big Beautiful Bill Act ("OBBBA"), enacted into law on July 4, 2025, allows for 100.0% expensing (i.e., Bonus Depreciation) for certain property acquired after January 19, 2025. Please note, state and local tax ("SALT") considerations as it relates to Section 179 and Section 168(k) were not implemented to align with a broader market participant perspective.
- (2) VMG utilized market participant levels of capital expenditures for the purposes of this analysis.
- (3) The selected incremental working capital requirement was based on VMG's review of guideline public company cash-free working capital levels. We note the selected level is consistent with guideline public company median.



Lower Keys Medical Center

Income Approach | Income Statement Projection

Final Report

Income Statement Projection	FY 2024	FY 2025	NBY	Projection Period					
				Year 1	Year 2	Year 3	Year 4	Year 5	Terminal Year
Net Operating Revenue									
Gross Inpatient Revenue	\$167,667,921	\$182,637,225	\$182,637,225	\$186,235,178	\$189,904,011	\$193,645,120	\$197,459,929	\$201,349,890	
Gross Outpatient Revenue	286,853,805	299,089,400	299,089,400	315,763,634	333,367,457	351,952,692	371,574,055	392,289,309	
Gross Inpatient Adjustments and Refunds	(118,290,417)	(130,045,013)	(130,045,013)	(133,000,628)	(136,070,504)	(139,309,521)	(142,617,554)	(145,996,013)	
Gross Outpatient Adjustments and Refunds	(201,848,436)	(211,335,302)	(211,335,302)	(223,771,113)	(237,161,284)	(251,339,865)	(266,352,729)	(282,248,396)	
Net Fee-for-Service Revenue	134,382,873	140,346,310	140,346,310	145,227,071	150,039,680	154,948,427	160,063,701	165,394,790	
Growth	n/a	4.4%	-	3.5%	3.3%	3.3%	3.3%	3.3%	
Bad Debt	(17,395,379)	(12,747,865)	(15,438,094)	(15,974,978)	(16,504,365)	(17,044,327)	(17,607,007)	(18,193,427)	
Other Operating Revenue	(306,401)	1,303,205	15,000	15,450	15,914	16,391	16,883	17,389	
Total Net Operating Revenue	116,681,093	128,901,650	124,923,216	129,267,544	133,551,229	137,920,491	142,473,576	147,218,752	150,163,127
Growth	n/a	10.5%	(3.1%)	3.5%	3.3%	3.3%	3.3%	3.3%	2.0%
Operating Expenses									
Employee Salaries and Wages	32,015,607	34,634,039	34,634,039	36,091,521	37,620,932	39,226,098	40,911,057	42,680,064	
Employee Benefits	6,368,600	7,233,998	7,233,998	7,538,422	7,857,869	8,193,140	8,545,076	8,914,568	
Occupancy Costs	1,915,989	2,217,155	2,217,155	2,283,670	2,352,180	2,422,745	2,495,427	2,570,290	
Drugs and Medical Supplies	8,779,280	8,977,450	8,977,450	9,355,242	9,751,679	10,167,752	10,604,509	11,063,051	
Insurance	3,129,119	4,017,727	4,017,727	4,138,259	4,262,407	4,390,279	4,521,987	4,657,647	
General and Administrative	28,020,929	32,243,377	32,243,377	33,489,211	34,778,513	36,121,685	37,526,630	38,996,445	
Total Operating Expenses	80,229,524	89,323,746	89,323,746	92,896,324	96,623,579	100,521,699	104,604,686	108,882,065	
Growth	n/a	11.3%	-	4.0%	4.0%	4.0%	4.1%	4.1%	
EBITDA	36,451,569	39,577,904	35,599,470	36,371,219	36,927,650	37,398,792	37,868,891	38,336,687	39,103,421
Growth	n/a	8.6%	(10.1%)	2.2%	1.5%	1.3%	1.3%	1.2%	2.0%
Depreciation and Amortization Expense	6,738,505	7,245,491	7,245,491	20,795,819	3,813,179	3,955,295	4,102,998	4,256,537	5,255,709
Interest Expense	199,197	165,531	-	-	-	-	-	-	-
Earnings Before Non-Operating Items	29,513,867	32,166,882	28,353,979	15,575,400	33,114,471	33,443,497	33,765,892	34,080,150	33,847,711
Non-Operating Expense (Income)	-	(858,202)	-	-	-	-	-	-	-
Earnings Before Income Taxes	29,513,867	33,025,084	28,353,979	15,575,400	33,114,471	33,443,497	33,765,892	34,080,150	33,847,711
Federal and State Income Tax Expense	-	-	7,186,316	3,947,585	8,392,863	8,476,254	8,557,965	8,637,614	8,578,702
Earnings After Income Taxes	\$29,513,867	\$33,025,084	\$21,167,663	\$11,627,815	\$24,721,609	\$24,967,243	\$25,207,927	\$25,442,536	\$25,269,009



Lower Keys Medical Center

Income Approach | Income Statement Projection

Final Report

				Projection Period					
Income Statement Projection	FY 2024	FY 2025	NBY	Year 1	Year 2	Year 3	Year 4	Year 5	Terminal Year
Common Size Basis									
Net Operating Revenue									
Gross Inpatient Revenue	143.7%	141.7%	146.2%	144.1%	142.2%	140.4%	138.6%	136.8%	
Gross Outpatient Revenue	245.8%	232.0%	239.4%	244.3%	249.6%	255.2%	260.8%	266.5%	
Gross Inpatient Adjustments and Refunds	(101.4%)	(100.9%)	(104.1%)	(102.9%)	(101.9%)	(101.0%)	(100.1%)	(99.2%)	
Gross Outpatient Adjustments and Refunds	(173.0%)	(164.0%)	(169.2%)	(173.1%)	(177.6%)	(182.2%)	(186.9%)	(191.7%)	
Net Fee-for-Service Revenue	115.2%	108.9%	112.3%	112.3%	112.3%	112.3%	112.3%	112.3%	
Bad Debt	(14.9%)	(9.9%)	(12.4%)	(12.4%)	(12.4%)	(12.4%)	(12.4%)	(12.4%)	
Other Operating Revenue	(0.3%)	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Total Net Operating Revenue	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Operating Expenses									
Employee Salaries and Wages	27.4%	26.9%	27.7%	27.9%	28.2%	28.4%	28.7%	29.0%	
Employee Benefits	5.5%	5.6%	5.8%	5.8%	5.9%	5.9%	6.0%	6.1%	
Occupancy Costs	1.6%	1.7%	1.8%	1.8%	1.8%	1.8%	1.8%	1.7%	
Drugs and Medical Supplies	7.5%	7.0%	7.2%	7.2%	7.3%	7.4%	7.4%	7.5%	
Insurance	2.7%	3.1%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	
General and Administrative	24.0%	25.0%	25.8%	25.9%	26.0%	26.2%	26.3%	26.5%	
Total Operating Expenses	68.8%	69.3%	71.5%	71.9%	72.3%	72.9%	73.4%	74.0%	
EBITDA	31.2%	30.7%	28.5%	28.1%	27.7%	27.1%	26.6%	26.0%	26.0%
Depreciation and Amortization Expense	5.8%	5.6%	5.8%	16.1%	2.9%	2.9%	2.9%	2.9%	3.5%
Interest Expense	0.2%	0.1%	-	-	-	-	-	-	-
Earnings Before Non-Operating Items	25.3%	25.0%	22.7%	12.0%	24.8%	24.2%	23.7%	23.1%	22.5%
Non-Operating Expense (Income)	-	(0.7%)	-	-	-	-	-	-	-
Earnings Before Income Taxes	25.3%	25.6%	22.7%	12.0%	24.8%	24.2%	23.7%	23.1%	22.5%
Federal and State Income Tax Expense	-	-	5.8%	3.1%	6.3%	6.1%	6.0%	5.9%	5.7%
Earnings After Income Taxes	25.3%	25.6%	16.9%	9.0%	18.5%	18.1%	17.7%	17.3%	16.8%



Lower Keys Medical Center

Income Approach | Discounted Cash Flow Multi-Period Method

Final Report

Discounted Cash Flow Multi-Period Method		Year 1	Year 2	Year 3	Year 4	Year 5	Terminal Year	Key Assumptions
EBITDA		\$36,371,219	\$36,927,650	\$37,398,792	\$37,868,891	\$38,336,687	\$39,103,421	
Depreciation and Amortization Expense		20,795,819	3,813,179	3,955,295	4,102,998	4,256,537	5,255,709	
Earnings Before Income Taxes		15,575,400	33,114,471	33,443,497	33,765,892	34,080,150	33,847,711	
Federal and State Income Tax Expense		3,947,585	8,392,863	8,476,254	8,557,965	8,637,614	8,578,702	25.3% Blended Federal and State (Florida) Tax Rate
Earnings After Income Taxes		11,627,815	24,721,609	24,967,243	25,207,927	25,442,536	25,269,009	
(+) Depreciation and Amortization Expense		20,795,819	3,813,179	3,955,295	4,102,998	4,256,537	5,255,709	
(-) Required Annual Capital Expenditures		(4,524,364)	(4,674,293)	(4,827,217)	(4,986,575)	(5,152,656)	(5,255,709)	
(-) Incremental Working Capital Requirements		(236,228)	(232,931)	(237,584)	(247,580)	(258,025)	(160,104)	5.4% of Incremental Total Net Operating Revenues
Net Discretionary Cash Flow		27,663,042	23,627,563	23,857,736	24,076,770	24,288,391	25,108,905	
Indicated Residual Value:							228,262,768	2.0% Estimated Long-Term Growth Rate
Partial Year Adjustment		1.00	1.00	1.00	1.00	1.00	1.00	
Present Value Period (Mid-Year Convention)		0.50	1.50	2.50	3.50	4.50	4.50	
Present Value Factor		0.9407	0.8325	0.7367	0.6520	0.5770	0.5770	13.0% Estimated Weighted Average Cost of Capital
Discounted Net Discretionary Cash Flows		\$26,023,200	\$19,669,860	\$17,576,529	\$15,697,254	\$14,013,472	\$131,698,881	
Sum of the Present Value of the Years One through Five Projected Cash Flows						\$92,980,316	41.4%	
Present Value of the Terminal Year						\$131,698,881	58.6%	
Fair Market Value Indication						\$224,679,196	100.0%	
Net Fixed Assets						\$27,946,508	11.2%	
Normalized Net Working Capital						\$6,792,863	2.7%	
Intangible Asset Value Indicated by the Income Approach						\$189,939,825	76.1%	
Tax Amortization Benefit						\$24,942,070	10.0%	Notes and Sources (1)
Fair Market Value Indication with Tax Amortization Benefit						\$249,621,267	100.0%	
Implied Multiples	NBY	Year 1	Year 2	Year 3	Year 4	Year 5	Terminal Year	
Fair Market Value Indication with Tax Amortization Benefit	2.00x	1.93x	1.87x	1.81x	1.75x	1.70x	1.66x	= BEV / Total Net Operating Revenue
	7.0x	6.9x	6.8x	6.7x	6.6x	6.5x	6.4x	= BEV / EBITDA

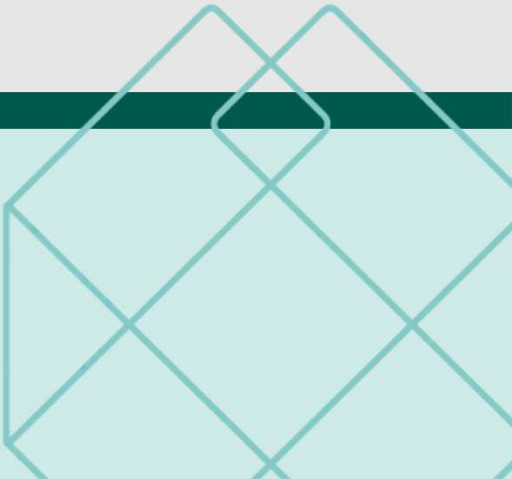
Notes and Sources

- (1) The Income Approach includes a tax amortization benefit ("TAB") to capture the tax amortization of goodwill. Goodwill, including all intangible assets, is created in a transaction when the purchase price exceeds the value of the working capital and fixed assets purchased by the buyer. Depending on the structure of the transaction, asset purchases and some stock purchases may result in an allocation of the purchase price to goodwill for tax purposes. The buyer's ability to amortize the goodwill for tax purposes results in an additional tax shield that is not reflected in the discounted cash flow. The TAB is simply the present value of the tax savings from this additional tax shield.



Lower Keys Medical Center

Cost of Capital



Capital Asset Pricing Model

Table with 2 columns: Component, Value. Rows include Cost of Equity (Ke), Equity Risk Premium (Rm), Subject Company Re-Levered Beta (Bi), Adjusted Market Risk Premium, Size Premium (Rs), Specific Company Risk Premium (Ru), Total Estimated Equity Risk Premium, Risk-Free Rate of Return (Rf), Total Cost of Equity (Ke), Equity as a Percent of Total Capital (We), and Pro-Rata Cost of Equity.

Table with 2 columns: Component, Value. Rows include Cost of Debt, Pre-Tax Cost of Debt (Kd), Tax Rate (t), After-Tax Cost of Debt, Debt as a Percent of Total Capital (Wd), and Pro-Rata Cost of Debt.

Table with 2 columns: Component, Value. Rows include Weighted Average Cost of Capital, Pro-Rata Cost of Equity, Pro-Rata Cost of Debt, and Weighted Average Cost of Capital (Unrounded).

Table with 2 columns: Component, Value. Row includes Selected Weighted Average Cost of Capital (Rounded).

Key Assumptions

Table with 2 columns: Formula/Assumption, Description. Rows include the CAPM formula, Supply Side Long-Term Equity Risk Premium, Beta Calculation, Size Premium, Specific Company Risk Premium, Risk-Free Rate, Debt Weighting, Moody's Seasoned Corporate Bond Yield, Corporate Income Tax Rate, Pre-Tax Cost of Debt, Debt Weighting, Weighted Average Cost of Capital formula, and the final Rounded Cost of Capital.



Notes and Sources

- (1) *The equity risk premium is the additional return an investor expects to receive to compensate for the risk associated with investing in equities as opposed to investing in riskless assets. The equity risk premium applied represents the Supply Side Long-Term Equity Risk Premium, per Kroll's Cost of Capital Navigator: U.S. Cost of Capital Module, as of Dec. 31, 2025. The selected equity risk premium was considered to reasonably represent a consensus viewpoint of the market equity risk premium.*
- (2) *The beta is a measure of statistical volatility, or systematic risk, of a company or an industry relative to the market as a whole. Beta is used to measure the price sensitivity of a company, or in this case an industry, in relation to changes in overall market prices. Public guideline company betas are unlevered in order to remove any positive effects they might receive by adding debt to their capital structures. These unlevered betas are then re-levered using the selected capital structure for the entity under question. Please refer to the Beta Calculation page for the publicly-traded guideline companies utilized and our calculation of beta.*
- (3) *The size (or small company) premium is the additional return an investor expects to receive to compensate for the additional risk associated with investing in a small, and inherently more risky, company. The size premium utilized was the Premium for the 10th Decile, per Kroll's CRSP Deciles Size Study, Cost of Capital Navigator: U.S. Cost of Capital Module, as of Dec. 31, 2025. The size premium was based on equity value before consideration of non-operating assets.*
- (4) *The final common component of the CAPM model is the specific company risk premium. The specific company risk quantifies the risk associated with the specific operations of the subject entity or the "unsystematic" risk of the subject entity. Our selection of a company specific risk premium adjusts not only for the additional risks inherent in the operations, but also accounts for the mitigating factors present in the operations. These risks are relative to the public markets from which the market equity risk premium, industry risk premium (beta), and small company risk premium were derived.*
- (5) *The risk-free rate is a proxy for the return available on a security that the market generally regards as free of default risk. The rate of return on a risk-free security was found by looking at the yields of United States Treasury securities. Ideally, the duration of the security used as an indication of the risk-free rate should match the horizon of the projected cash flows being discounted (which is into perpetuity in the present case). We used the available United States Treasury Constant Maturity, 20 Year, per S&P's Capital IQ as of Jun. 16, 2026.*
- (6) *We reviewed capital structures for public companies operating in the industry, the current capital structure of the subject entity, and our experience with similar businesses in selecting the capital structure utilized in the WACC analysis.*
- (7) *The cost of debt utilized in the calculation of the WACC was based upon the available Moody's Seasoned Corporate Bond Yield, Percent, Daily, Not Seasonally Adjusted, Rating Baa, as of May 26, 2026.*
- (8) *To calculate the after-tax cost of debt component in the WACC formula, we utilized the blended state and federal income tax rate applicable to the state of Florida.*



Company Name	Credit Rating ⁽²⁾	Market Cap.	Total Debt ⁽³⁾	Minority Interest	Debt / TIC ⁽³⁾	Debt / Equity	Tax Rate ⁽⁴⁾	Levered Beta ⁽⁵⁾	Unlevered Beta ⁽⁶⁾
1. HCA Healthcare, Inc.	BBB	\$88,054,872	\$48,023,000	\$3,325,000	34.4%	52.6%	21.0%	0.7661	0.5415
2. Tenet Healthcare Corporation	BB-	\$15,811,308	\$13,209,000	\$4,036,000	40.0%	66.6%	20.8%	1.2066	0.7900
3. Universal Health Services, Inc.	BB+	\$8,892,790	\$4,708,358	\$139,622	34.3%	52.1%	23.3%	0.8148	0.5821

Statistical Analysis									
Median					34.4%	52.6%	21.0%	0.8148	0.5821
Mean					36.2%	57.1%	21.7%	0.9292	0.6379

Relevered Beta Calculation

Public Comparable Unlevered Beta	0.5821
Debt / TIC	34.4%
(+) Equity / TIC	65.6%
(=) Debt / Equity	52.6%
Blended Federal and State (FL) Corporate Income Tax Rate	25.3%
Relevered Beta	0.8105

Notes and Sources

- (1) Source(s): S&P's Capital IQ as of June 16, 2026. Historical financials are "Latest" (i.e., information is retrieved from the most recent period, including press releases). Estimates are consolidated (i.e., includes the parent company and all subsidiaries). Source financials retrieved are as of the company's period end date. Where applicable, the historical spot exchange rate on the period end date is applied to foreign currency types across all historical periods. Unless otherwise noted, data is presented in USD (\$), in thousands.
- (2) Reflects S&P Global Issuer Credit Ratings, Local Currency, Long-Term
- (3) The Debt / TIC ratio was sourced from S&P's Capital IQ, and represents the median of the public companies' debt structure. Please note, the debt figures exclude lease liabilities.
- (4) A 5 Year effective tax rate was calculated to match the beta calculation period and adjust for single-period inconsistencies.
- (5) The 5 Year Levered Beta was sourced from S&P's Capital IQ, and was computed by taking the slope of a weekly regression line of the percent change of the stock relative to the percentage price change in the S&P 500.
- (6) $Unlevered\ Beta = Levered\ Beta / \{ 1 + [(Debt \div Equity) \times (1 - T)] \}$
- (7) $Relevered\ Beta = Unlevered\ Beta \times \{ 1 + [(Debt \div Equity) \times (1 - T)] \}$



Effect ⁽¹⁾	Company-Specific Risk Factors
+	Reputation in the local community
+	Diversified specialty mix
+	Low level of competition in the marketplace
–	Potential for degrading payor mix due to aging population and government budget deficits
–	Changing CON laws in Florida
–	Transition risk due to potential change in operator at lease renewal
–	Operational disruption risk due to Hospital Modernization
–	OBBA impact
–	Weather risk due to geography
–	Lack of growth opportunity due to isolated geography and low population growth

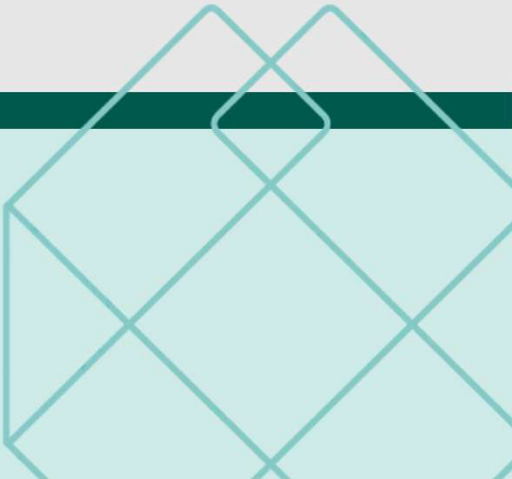
Notes and Sources

(1) = No net effect (Neutral) + Decreases Risk (Favorable) – Increases Risk (Unfavorable)



Lower Keys Medical Center

Cost Approach



				Stated as a % of BEV	
Build-Up Approach	Dec. 31, 2025	Adjustments	Estimated Value	Estimated Value	Key Assumptions
Estimated Normalized Net Working Capital			6,792,863	18.8%	= Current Assets - Current Liabilities Estimated at 5.4% of Total Net Operating Revenue
Fixed Assets					
Building Improvements	32,711,752	(2,091,073)	30,620,679	84.7%	Estimated value based on the Dec. 31, 2025 balance sheet
Leasehold Improvements	-	-	-	-	Estimated value based on the Dec. 31, 2025 balance sheet
Equipment and Fixtures	31,396,313	(71,836)	31,324,477	86.7%	Estimated value based on the Dec. 31, 2025 balance sheet
Right-of-Use ("ROU") Finance Lease	25,730,000	-	25,730,000	71.2%	Estimated value based on the Dec. 31, 2025 balance sheet
Construction in Progress	1,585,580	-	1,585,580	4.4%	Estimated value based on the Dec. 31, 2025 balance sheet
Accumulated Depreciation	(61,314,228)	-	(61,314,228)	(169.7%)	Estimated value based on the Dec. 31, 2025 balance sheet
Total Fixed Assets	30,109,417		27,946,508	77.3%	
Other Assets					
Right-of-Use ("ROU") Operating Lease	1,128,386	(1,128,386)	-	-	Not considered part of in-exchange premise of value
Other Deferred Costs	1,184,895	-	1,184,895	3.3%	
Deferred Miscellaneous Charges	200,609	-	200,609	0.6%	
Security Deposits	6,700	-	6,700	0.0%	
	2,520,590	(1,128,386)	1,392,204	3.9%	
Fair Market Value Indication			\$36,131,575	100.0%	

Notes and Sources

- (1) VMG was provided a fixed asset ledger for the reporting unit "1005". Per direction from Hospital management, VMG identified assets with the term "DePoo" indicated in the asset description to isolate fixed assets specific to DePoo behavioral health services. The net balances of these assets according to the provided fixed asset ledger were removed from the December 31, 2025 "1005" balance sheet in order to estimate total Net Fixed Assets associated with solely with the Hospital.



Fixed Asset Ledger Summary by Category		Acquisition Cost	Accum. Depr.	Book Value	Adjustments ⁽²⁾	Book Value
1.	Building-Owned	\$35,954	(\$23,712)	\$12,242	-	\$12,242
2.	Building Improve-Owned	\$32,675,798	(\$17,029,718)	\$15,646,079	(\$2,091,073)	\$13,555,006
3.	Equipment-Owned	\$5,653,781	(\$3,504,640)	\$2,149,141	(\$30,777)	\$2,118,364
4.	Moveable Equipment-Owned	\$18,523,004	(\$13,768,583)	\$4,754,422	-	\$4,754,422
5.	Minor Equipment-Owned	\$6,840,708	(\$6,281,547)	\$559,161	(\$40,691)	\$518,470
6.	Furniture & Fixtures-Owned	\$345,265	(\$228,247)	\$117,017	(\$368)	\$116,649
7.	Transportation-Owned	\$33,555	(\$33,555)	-	-	-
8.	Deferred-MIS	\$10,484,844	(\$10,284,235)	\$200,609	-	\$200,609
Total Fixed Assets		\$74,592,908	(\$51,154,237)	\$23,438,672	(\$2,162,909)	\$21,275,763

Notes and Sources

- (1) Source(s): "Fixed Asset Listing for 1005 as of 12.31.25.xlsx"
- (2) Based on documentation provided by Hospital management, the provided fixed asset ledger relates to the entity "1005" only. This entity includes the DePoo facility. Further, Hospital management indicated unless the asset description indicates "DePoo", there is not a direct way to identify what assets are specific to the DePoo facility. Therefore, the "Adjustments" column reflects the removal of any assets in which the "ORACLE ASSET DESCRIPTION" column in the provided fixed asset ledger includes "DePoo", "DEPOO", or "depoo" text.



Final Report

Lower Keys Medical Center

Market Approach

Strictly Private and Confidential

Capitalization Data	Ticker	Market Cap.	Total Debt	Minority Interest	Preferred Equity	Cash & Equivalents	TIC
1. HCA Healthcare, Inc.	HCA	\$88,054,872	\$48,023,000	\$3,325,000	-	\$1,064,000	\$139,402,872
2. Tenet Healthcare Corporation	THC	\$15,811,308	\$13,209,000	\$4,036,000	-	\$2,967,000	\$33,056,308
3. Universal Health Services, Inc.	UHS	\$8,892,790	\$4,708,358	\$139,622	-	\$119,028	\$13,740,770
4. Community Health Systems, Inc.	CYH	\$425,323	\$10,156,000	\$489,000	-	\$712,000	\$11,070,323
5. Ardent Health, Inc.	ARDT	\$1,327,421	\$1,115,232	\$394,390	-	\$611,216	\$2,837,043

Financial Performance	Ticker	Revenue			EBITDA (Including Equity from Affiliates)		
		TTM	FY + 1	FY + 2	TTM	FY + 1	FY + 2
1. HCA Healthcare, Inc.	HCA	\$76,388,000	\$78,563,396	\$82,353,429	\$15,635,000	\$15,913,599	\$16,698,438
2. Tenet Healthcare Corporation	THC	\$21,455,000	\$21,992,098	\$22,352,216	\$4,894,000	\$4,660,517	\$4,713,260
3. Universal Health Services, Inc.	UHS	\$17,760,291	\$18,522,171	\$19,414,039	\$2,668,874	\$2,698,461	\$2,787,996
4. Community Health Systems, Inc.	CYH	\$12,291,000	\$11,596,117	\$11,779,092	\$1,397,000	\$1,353,936	\$1,406,434
5. Ardent Health, Inc.	ARDT	\$6,428,975	\$6,552,681	\$6,853,500	\$501,893	\$514,825	\$534,397

Valuation Multiples	Ticker	Revenue			EBITDA (Including Equity from Affiliates)		
		TTM	FY + 1	FY + 2	TTM	FY + 1	FY + 2
1. HCA Healthcare, Inc.	HCA	1.82x	1.77x	1.69x	8.92x	8.76x	8.35x
2. Tenet Healthcare Corporation	THC	1.54x	1.50x	1.48x	6.75x	7.09x	7.01x
3. Universal Health Services, Inc.	UHS	0.77x	0.74x	0.71x	5.15x	5.09x	4.93x
4. Community Health Systems, Inc.	CYH	0.90x	0.95x	0.94x	7.92x	8.18x	7.87x
5. Ardent Health, Inc.	ARDT	0.44x	0.43x	0.41x	5.65x	5.51x	5.31x

Statistical Analysis							
Low	0.44x	0.43x	0.41x	5.15x	5.09x	4.93x	
25th Percentile	0.77x	0.74x	0.71x	5.65x	5.51x	5.31x	
Median	0.90x	0.95x	0.94x	6.75x	7.09x	7.01x	
Mean	1.10x	1.08x	1.05x	6.88x	6.93x	6.69x	
75th Percentile	1.54x	1.50x	1.48x	7.92x	8.18x	7.87x	
High	1.82x	1.77x	1.69x	8.92x	8.76x	8.35x	

Notes and Sources

- (1) Source(s): S&P's Capital IQ as of June 16, 2026. Historical financials are "Latest" (i.e., information is retrieved from the most recent period, including press releases). Estimates are consolidated (i.e., includes the parent company and all subsidiaries). Source financials retrieved are as of the company's period end date. Where applicable, the historical spot exchange rate on the period end date is applied to foreign currency types across all historical periods. Unless otherwise noted, data is presented in USD (\$), in thousands.
- (2) Total Invested Capital ("TIC") is defined as Market Value of Equity plus Interest-bearing Debt.
- (3) Please note, the Total Debt figures presented reflect Total Debt (Excluding Lease Liabilities).



Key Trends by Company	Ticker	FY - 2	FY - 1	FYE	TTM	FY + 1	FY + 2	FY + 3
Revenue Growth								
1. HCA Healthcare, Inc.	HCA	7.9%	8.7%	7.1%	1.0%	2.8%	4.8%	5.5%
2. Tenet Healthcare Corporation	THC	7.2%	0.5%	3.1%	0.7%	2.5%	1.6%	5.3%
3. Universal Health Services, Inc.	UHS	6.6%	10.8%	9.7%	2.3%	4.3%	4.8%	5.5%
4. Community Health Systems, Inc.	CYH	2.3%	1.2%	(1.2%)	(1.6%)	(5.7%)	1.6%	1.1%
5. Ardent Health, Inc.	ARDT	5.5%	10.3%	6.0%	1.7%	1.9%	4.6%	5.1%
Median of the Guideline Companies:		6.6%	8.7%	6.0%	1.0%	2.5%	4.6%	5.3%
Average of the Guideline Companies:		5.9%	6.3%	4.9%	0.8%	1.2%	3.5%	4.5%

EBITDA (Including Equity from Affiliates, Excluding Operating Lease Adjustment) Growth								
1. HCA Healthcare, Inc.	HCA	5.4%	9.1%	12.1%	0.4%	1.8%	4.9%	5.4%
2. Tenet Healthcare Corporation	THC	10.2%	10.1%	14.0%	(0.1%)	(4.8%)	1.1%	5.5%
3. Universal Health Services, Inc.	UHS	6.1%	30.0%	15.3%	2.1%	1.1%	3.3%	4.8%
4. Community Health Systems, Inc.	CYH	10.2%	(3.4%)	15.6%	(4.0%)	(3.1%)	3.9%	4.8%
5. Ardent Health, Inc.	ARDT	5.4%	54.8%	(12.8%)	4.3%	2.6%	3.8%	5.8%
Median of the Guideline Companies:		6.1%	10.1%	14.0%	0.4%	1.1%	3.8%	5.4%
Average of the Guideline Companies:		7.5%	20.1%	8.8%	0.5%	(0.5%)	3.4%	5.2%

EBITDA (Including Equity from Affiliates) Margin								
1. HCA Healthcare, Inc.	HCA	19.6%	19.7%	20.6%	20.5%	20.3%	20.3%	20.2%
2. Tenet Healthcare Corporation	THC	19.0%	20.8%	23.0%	22.8%	21.2%	21.1%	21.1%
3. Universal Health Services, Inc.	UHS	12.2%	14.3%	15.1%	15.0%	14.6%	14.4%	14.3%
4. Community Health Systems, Inc.	CYH	10.4%	10.0%	11.7%	11.4%	11.7%	11.9%	12.4%
5. Ardent Health, Inc.	ARDT	6.6%	9.3%	7.6%	7.8%	7.9%	7.8%	7.8%
Median of the Guideline Companies:		12.2%	14.3%	15.1%	15.0%	14.6%	14.4%	14.3%
Average of the Guideline Companies:		13.6%	14.8%	15.6%	15.5%	15.1%	15.1%	15.2%

Capital Expenditures (As a Percent of Revenues)								
1. HCA Healthcare, Inc.	HCA	7.3%	6.9%	6.5%	6.6%	n/a	n/a	n/a
2. Tenet Healthcare Corporation	THC	3.7%	4.5%	4.7%	4.7%	n/a	n/a	n/a
3. Universal Health Services, Inc.	UHS	5.2%	6.0%	5.8%	5.6%	n/a	n/a	n/a
4. Community Health Systems, Inc.	CYH	3.7%	2.8%	2.7%	2.7%	n/a	n/a	n/a
5. Ardent Health, Inc.	ARDT	2.5%	3.1%	3.4%	3.4%	n/a	n/a	n/a
Median of the Guideline Companies:		3.7%	4.5%	4.7%	4.7%	n/a	n/a	n/a
Average of the Guideline Companies:		4.5%	4.7%	4.6%	4.6%	n/a	n/a	n/a

Net Working Capital (As a Percent of Revenues)								
1. HCA Healthcare, Inc.	HCA	7.8%	8.9%	6.2%	7.0%	n/a	n/a	n/a
2. Tenet Healthcare Corporation	THC	13.3%	17.7%	17.3%	10.7%	n/a	n/a	n/a
3. Universal Health Services, Inc.	UHS	7.0%	4.6%	5.7%	6.1%	n/a	n/a	n/a
4. Community Health Systems, Inc.	CYH	9.7%	8.6%	9.2%	10.8%	n/a	n/a	n/a
5. Ardent Health, Inc.	ARDT	12.7%	15.8%	17.2%	17.2%	n/a	n/a	n/a
Median of the Guideline Companies:		9.7%	8.9%	9.2%	10.7%	n/a	n/a	n/a
Average of the Guideline Companies:		10.1%	11.1%	11.1%	10.4%	n/a	n/a	n/a



Key Trends by Company		Ticker	FY - 2	FY - 1	FYE	TTM	FY + 1	FY + 2	FY + 3
Cash-Free Net Working Capital (As a Percent of Revenues)									
1.	HCA Healthcare, Inc.	HCA	6.2%	6.0%	4.7%	5.6%	n/a	n/a	n/a
2.	Tenet Healthcare Corporation	THC	7.3%	3.1%	3.7%	(3.2%)	n/a	n/a	n/a
3.	Universal Health Services, Inc.	UHS	6.1%	3.8%	4.9%	5.4%	n/a	n/a	n/a
4.	Community Health Systems, Inc.	CYH	9.4%	8.3%	7.1%	5.0%	n/a	n/a	n/a
5.	Ardent Health, Inc.	ARDT	4.3%	6.3%	6.0%	7.7%	n/a	n/a	n/a
Median of the Guideline Companies:			6.2%	6.0%	4.9%	5.4%	n/a	n/a	n/a
Average of the Guideline Companies:			6.7%	5.5%	5.3%	4.1%	n/a	n/a	n/a
Capital Structure (Debt to Total Invested Capital)									
1.	HCA Healthcare, Inc.	HCA	34.5%	35.2%	29.7%	30.6%	n/a	n/a	n/a
2.	Tenet Healthcare Corporation	THC	56.4%	44.6%	37.2%	39.2%	n/a	n/a	n/a
3.	Universal Health Services, Inc.	UHS	32.0%	27.4%	25.7%	29.8%	n/a	n/a	n/a
4.	Community Health Systems, Inc.	CYH	92.2%	92.0%	91.5%	92.0%	n/a	n/a	n/a
5.	Ardent Health, Inc.	ARDT	n/a	27.9%	39.8%	40.8%	n/a	n/a	n/a
Median of the Guideline Companies:			45.5%	35.2%	37.2%	39.2%	n/a	n/a	n/a
Average of the Guideline Companies:			53.8%	45.4%	44.8%	46.5%	n/a	n/a	n/a

Notes and Sources

- (1) Source(s): S&P's Capital IQ as of June 16, 2026. Historical financials are "Latest" (i.e., information is retrieved from the most recent period, including press releases). Estimates are consolidated (i.e., includes the parent company and all subsidiaries). Source financials retrieved are as of the company's period end date. Where applicable, the historical spot exchange rate on the period end date is applied to foreign currency types across all historical periods. Unless otherwise noted, data is presented in USD (\$), in thousands.
- (2) Please note, the Debt figures presented above exclude lease liabilities.



HCA	HCA Healthcare, Inc., through its subsidiaries, provides health care services in the United States. The company owns, manages, and operates hospitals, ASCs, freestanding emergency care facilities, urgent care facilities, walk-in clinics, diagnostic and imaging centers, radiation and oncology therapy centers, as well as rehabilitation and physical therapy centers, physician practices, home health agencies, hospices, outpatient physical therapy providers, home and community-based services providers, and various other facilities. Its general and acute care hospitals offer medical and surgical services, including inpatient care, intensive care, cardiac care, diagnostic services, and emergency services; and outpatient services, such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology, and physical therapy. The company was formerly known as HCA Holdings, Inc. HCA Healthcare, Inc. was founded in 1968 and is headquartered in Nashville, Tennessee.
THC	Tenet Healthcare Corporation operates as a diversified healthcare services company in the United States. The company operates through two segments: Hospital Operations and Services, and Ambulatory Care. Its general hospitals offer acute care services, operating and recovery rooms, radiology and respiratory therapy services, clinical laboratories, and pharmacies. The company also provides intensive and critical care, and/or coronary care units; cardiovascular, digestive disease, neurosciences, musculoskeletal, and obstetrics services; outpatient services, including physical therapy; tertiary care services, such as cardiothoracic surgery, complex spinal surgery, neonatal intensive care, and neurosurgery services; pediatric quaternary care services through heart, liver, and kidney transplants programs; and limb salvaging vascular procedure, acute level 1 trauma, intravascular stroke care, minimally invasive cardiac valve replacement, imaging technology, surgical robotic, and telemedicine access services. In addition, it offers a range of procedures and services comprising orthopedics, total joint replacement, and spinal and other musculoskeletal procedures; gastroenterology; pain management; otolaryngology; ophthalmology; and urology. Further, the company operates acute care and specialty hospitals, off-campus emergency departments, imaging centers, urgent care centers, and micro-hospitals, as well as ambulatory surgery centers and surgical hospitals. Tenet Healthcare Corporation was founded in 1967 and is headquartered in Dallas, Texas.
UHS	Universal Health Services, Inc., through its subsidiaries, owns and operates acute care hospitals, and outpatient and behavioral health care facilities in the United States. It operates through Acute Care Hospital Services and Behavioral Health Care Services segments. The company's hospitals offer general and specialty surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic and coronary care, pediatric, pharmacy, and/or behavioral health services. It also provides commercial health insurance services; capital resources; and various management services, including central purchasing, information services, finance and control systems, facilities planning, physician recruitment, administrative personnel management, marketing, and public relations services. Universal Health Services, Inc. was founded in 1978 and is headquartered in King of Prussia, Pennsylvania.
CYH	Community Health Systems, Inc. owns, leases, and operates general acute care hospitals in the United States. The company offers general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric, and rehabilitation services, as well as skilled nursing and home care services. It also provides outpatient services at primary care practices, urgent care centers, free-standing emergency departments, ambulatory surgery centers, imaging and diagnostic centers, and direct-to-consumer virtual health visits. Community Health Systems, Inc. was founded in 1985 and is headquartered in Franklin, Tennessee.
ARDT	Ardent Health, Inc. owns and operates a network of hospitals and clinics that provides healthcare services in the United States. The company offers general and specialty services, including internal medicine, general surgery, cardiology, oncology, orthopedics, women's services, neurology, urology, and emergency services within inpatient and ambulatory care settings. It also operates a network of ambulatory facilities and telehealth services, including primary care and specialty care clinics, ambulatory surgery centers, urgent care centers, free-standing emergency departments, and diagnostic imaging centers. The company operates acute care hospitals, including rehabilitation hospitals and surgical hospitals. Ardent Health, Inc. was formerly known as Ardent Health Partners, Inc. and changed its name to Ardent Health, Inc. in June 2025. The company was founded in 2001 and is based in Brentwood, Tennessee. Ardent Health, Inc. is a subsidiary of EGI-AM Investments, L.L.C.

Notes and Sources

- (1) Source(s): S&P's Capital IQ as of June 16, 2026. Historical financials are "Latest" (i.e., information is retrieved from the most recent period, including press releases). Estimates are consolidated (i.e., includes the parent company and all subsidiaries). Source financials retrieved are as of the company's period end date. Where applicable, the historical spot exchange rate on the period end date is applied to foreign currency types across all historical periods. Unless otherwise noted, data is presented in USD (\$), in thousands.



Measure of Performance	Selected Multiples			Hospital Results	Indicated Value			Weight	Conclusion		
	Low	Midpoint	High		Low	Midpoint	High		Low	Midpoint	High
BEV / NBY EBITDA	6.00x	7.00x	8.00x	\$35,599,470	\$213,596,819	\$249,196,289	\$284,795,759	100.0%	213,596,819	249,196,289	284,795,759
Fair Market Value Indication(s)									\$213,596,819	\$249,196,289	\$284,795,759

Notes and Sources

- (1) Source(s): S&P's Capital IQ as of June 16, 2026. Historical financials are "Latest" (i.e., information is retrieved from the most recent period, including press releases). Estimates are consolidated (i.e., includes the parent company and all subsidiaries). Source financials retrieved are as of the company's period end date. Where applicable, the historical spot exchange rate on the period end date is applied to foreign currency types across all historical periods. Unless otherwise noted, data is presented in USD (\$), in thousands.
- (2) VMG selected the low and high multiples based on the 25th and 75th percentile multiples from the guideline public companies and VMG's professional judgement. VMG utilized the GPC Method as a corroborative approach but did not rely on it due to differences in geography, growth, size, service line diversification, level of control, and liquidity/transaction costs.



Complete Database	BEV / Revenue	BEV / EBITDA	EBITDA Margin
<i>Reflects all identified transaction multiples, excluding outlier EBITDA multiples exceeding 20.0x, occurring from March 19, 2010 to March 31, 2026</i>			
Number of Observations	251	125	124
Minimum	0.04x	0.77x	0.9%
25th Percentile	0.30x	5.85x	5.7%
50th Percentile	0.55x	8.48x	9.6%
Mean	0.67x	8.52x	10.3%
75th Percentile	0.92x	9.94x	13.8%
Maximum	4.35x	18.40x	29.7%

Complete Database: Revenue Adjusted	BEV / Revenue	BEV / EBITDA	EBITDA Margin
<i>Reflects all identified transaction multiples, excluding outlier EBITDA multiples exceeding 20.0x, occurring from March 19, 2010 to March 31, 2026, involving targets with Operating Revenue between \$50,000,000 and \$200,000,000</i>			
Number of Observations	103	56	56
Minimum	0.06x	1.93x	0.9%
25th Percentile	0.27x	4.85x	4.4%
50th Percentile	0.53x	7.71x	7.7%
Mean	0.62x	8.18x	9.4%
75th Percentile	0.81x	9.77x	12.4%
Maximum	3.21x	18.40x	26.8%

Complete Database: Operationally Similar to LKMC	BEV / Revenue	BEV / EBITDA	EBITDA Margin
<i>Reflects all identified transaction multiples, excluding outlier EBITDA multiples exceeding 20.0x, occurring from March 19, 2010 to March 31, 2026, involving targets (i) with EBITDA margins in excess of 15.0%, (ii) Operating Revenue between \$50,000,000 and \$200,000,000, and (iii) that are located in the South (i.e., Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, West Virginia)</i>			
Number of Observations	8	8	8
Minimum	0.55x	2.57x	16.3%
25th Percentile	0.96x	4.04x	20.0%
50th Percentile	1.31x	6.48x	21.5%
Mean	1.60x	7.83x	21.2%
75th Percentile	1.98x	11.13x	22.0%
Maximum	3.21x	15.80x	26.8%

Complete Database: EBITDA Adjusted	BEV / Revenue	BEV / EBITDA	EBITDA Margin
<i>Reflects all identified transaction multiples, excluding outlier EBITDA multiples exceeding 20.0x, occurring from March 19, 2010 to March 31, 2026, involving targets with EBITDA margins in excess of 15.0%</i>			
Number of Observations	22	22	22
Minimum	0.34x	1.92x	15.6%
25th Percentile	1.05x	4.58x	17.2%
50th Percentile	1.41x	7.89x	19.3%
Mean	1.61x	7.81x	20.4%
75th Percentile	1.87x	9.46x	21.9%
Maximum	4.35x	16.00x	29.7%

Complete Database: Geographically Adjusted	BEV / Revenue	BEV / EBITDA	EBITDA Margin
<i>Reflects all identified transaction multiples, excluding outlier EBITDA multiples exceeding 20.0x, occurring from March 19, 2010 to March 31, 2026, involving targets with operations in the South (i.e., Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, West Virginia)</i>			
Number of Observations	135	73	72
Minimum	0.04x	0.77x	0.9%
25th Percentile	0.28x	5.78x	5.9%
50th Percentile	0.56x	8.52x	9.6%
Mean	0.71x	8.40x	11.0%
75th Percentile	0.92x	10.52x	14.6%
Maximum	4.35x	17.71x	29.7%

Notes and Sources

(1) Transactions sourced from Irving Levin Associates' Database, Capital IQ, and proprietary information



Measure of Performance	Selected Multiples			Hospital Results	Indicated Value			Weight	Conclusion		
	Low	Midpoint	High		Low	Midpoint	High		Low	Midpoint	High
BEV / NBY EBITDA	5.00x	7.50x	10.00x	\$35,599,470	177,997,350	266,996,024	355,994,699	100.0%	177,997,350	266,996,024	355,994,699
Fair Market Value Indication(s)									\$177,997,350	\$266,996,024	\$355,994,699

Notes and Sources

- (1) Transactions sourced from Irving Levin Associates' Database, Capital IQ, and proprietary information
- (2) VMG selected the low and high multiples based on the 25th and 75th percentile multiples from the observed merger and acquisition multiples, VMG's professional judgement, and the specific facts and circumstances of the Hospital. VMG relied on the Midpoint to establish FMV indication .



Final Report

Lower Keys Medical Center

Hospital Modernization Analysis

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Discounted Cash Flow Multi-Period Method	Current	Year 10	Year 11	Year 12	Key Assumptions
Scenario One					Based on the file titled
Current Replacement Value	\$74,787,000				"BLKMC_Lower Keys Medical Center_ISES Corp FCA"
Total Estimated Modernization Costs	\$74,787,000				Notes and Sources (1)
Inflation Adjustment	3.0%				
Time Horizon	10.0				
Inflation-Adjusted Total Estimated Modernization Costs	\$100,507,474				
Allocation of Projected Modernization Costs Estimated Across Time to Complete Modernization		50.0%	25.0%	25.0%	Notes and Sources (1)
Total Estimated Modernization Costs		\$50,253,737	\$25,126,869	\$25,126,869	
Present Value Period (Mid-Year Convention)		9.50	10.50	11.50	
Present Value Factor		0.5718	0.5391	0.5083	Notes and Sources (2)
Discounted Net Discretionary Cash Flows		\$28,736,108	\$13,547,100	\$12,773,053	
Scenario One Present Value Indication				\$55,056,261	
Scenario Two					Based on Client representations and third-party advisors
Current Replacement Value	\$150,000,000				Notes and Sources (1)
Total Estimated Modernization Costs	\$150,000,000				
Inflation Adjustment	3.0%				
Time Horizon	10.0				
Inflation-Adjusted Total Estimated Modernization Costs	\$201,587,457				
Allocation of Projected Modernization Costs Estimated Across Time to Complete Modernization		50.0%	25.0%	25.0%	Notes and Sources (1)
Total Estimated Modernization Costs		\$100,793,728	\$50,396,864	\$50,396,864	
Present Value Period (Mid-Year Convention)		9.50	10.50	11.50	
Present Value Factor		0.5718	0.5391	0.5083	Notes and Sources (2)
Discounted Net Discretionary Cash Flows		\$57,635,902	\$27,171,366	\$25,618,863	
Scenario Two Present Value Indication				\$110,426,131	

Notes and Sources

- (1) According to documentation provided by the District, the Hospital was constructed in the late 1960s and has been maintained, but has aged over time. Further, while the existing facility can support immediate hospital operations, there is an opportunity to develop a new health facility that reflects state-of-the-art approaches to patient care, including the increasing prevalence of outpatient care modalities, new technologies and equipment, and emerging adjacency opportunities (i.e., "Hospital Modernization"). To account for the Hospital Modernization need, VMG adjusted the Fair Market Value Indication of the Hospital for an "Assumed Cost of Modernization of Hospital". The Assumed Cost of Modernization of Hospital was calculated in range based on the "Replacement Value" of the Hospital as reported in the Engineering Report provided by District, discussions with Client and the representations of their advisors. Please note, these costs may not include the required furniture, fixtures, and equipment, which may be incremental to the cost estimates. These cost estimates were inflation-adjusted, and VMG assumed the Hospital Modernization may begin in ten (10) years, and take approximately three (3) years to complete. These inflation-adjusted costs were discounted to present value using a discount rate consistent with the current cost of debt. VMG has not opined on the replacement value of the Hospital. To the extent that estimates from third parties are inaccurate, the FMV opinion may be impacted. Additionally, VMG has assumed that a hypothetical lessee will enter into a long-enough term lease with the District to earn a return on its investment on any Hospital Modernization efforts, and fund all of the capital necessary. To the extent that the District funds any capital related to Hospital Modernization, the valuation opinion may be materially impacted. VMG has assumed that there will be no disruptions to operations as part of any Hospital Modernization endeavors.
- (2) = 6.1% per Moody's Seasoned Corporate Bond Yield, Percent, Daily, Not Seasonally Adjusted, Rating Baa, as of May 26, 2026



Final Report

Lower Keys Medical Center

Operational and Quality Benchmarking Analysis

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Final Report

Lower Keys Medical Center

Peer Group Identification

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Lower Keys Medical Center Selected Peer Group

VMG compiled a list of all hospitals within approximately 250 miles of LKMC and gathered general information and high level operating statistics. VMG further refined the appropriate comparable set for LKMC based on the number of beds and patient days. VMG also considered the services provided according to the information listed below. After analyzing our compiled data set, we selected the hospitals on the following page to benchmark against LKMC. Hospitals were excluded for lack of comparability based on size, operating statistics, programs, special services, and other data issues. The following page details the selected hospitals ultimately considered pursuant to the quality and cost comparison analysis.

Description

- Facility Name
- County
- Profit Status
- Owner/Operator
- Distance (Miles)
- Type of Control
- Baker Act Receiving Facility

Operating Statistics

- Case Mix Index ("CMI")
- Gross Revenue
- Acute Patient Days
- Discharges

Programs and/or Services

- Level I Adult Cardiovascular Services
- Level II Adult Cardiovascular Services
- Primary Stroke Center
- Emergency Services Provided

Bed Types

- Acute Bed Count
- Specialty and/or Other Bed Type Count

Notes and Sources

- (1) Source(s): [ahd.com](#)
- (2) Source(s): <https://www.medicare.gov/care-compare/>



Lower Keys Medical Center Selected Peer Group

Facility Name	Type of Control	City	County	Distance (Miles)	Beds	Gross Revenue	Discharges	Acute Patient Days
1. Lower Keys Medical Center	Proprietary, Corporation	Key West	Monroe County	0.0	124	\$516,072,353	2,352	8,896
2. Larkin Hospital Palm Springs	Proprietary, Corporation	Hialeah	Miami-Dade County	126.2	119	\$526,097,287	3,007	20,950
3. Keralty Hospital	Proprietary, Corporation	Miami	Miami-Dade County	120.2	125	\$180,950,968	2,238	11,061
4. Larkin Community Hospital South Miami	Proprietary, Corporation	South Miami	Miami-Dade County	119.4	128	\$433,214,640	5,959	28,835
5. HCA Florida University Hospital	Proprietary, Corporation	Davie	Broward County	139.1	155	\$1,640,339,989	6,884	28,518
6. Coral Gables Hospital	Proprietary, Other	Coral Gables	Miami-Dade County	122.9	245	\$1,512,046,128	2,850	9,298
7. Homestead Hospital	Voluntary Nonprofit, Other	Homestead	Miami-Dade County	103.0	169	\$1,686,460,547	9,305	33,780
8. Broward Health Imperial Point	Governmental Hospital District	Fort Lauderdale	Broward County	151.7	174	\$650,755,102	4,028	16,897
9. Memorial Hospital Miramar	Governmental Hospital District	Miramar	Broward County	129.7	178	\$1,820,648,745	10,251	46,644
10. Memorial Hospital Pembroke	Governmental Hospital District	Pembroke Pines	Broward County	137.0	195	\$1,645,009,027	24,243	38,126
11. Broward Health Coral Springs	Governmental Hospital District	Coral Springs	Broward County	149.1	224	\$1,275,513,019	10,984	51,432
12. Sarasota Memorial Hospital Venice	Governmental, County	Venice	Sarasota County	181.6	212	\$2,019,279,486	15,795	66,553

Notes and Sources

(1) Source(s): ahd.com



Final Report

Lower Keys Medical Center

Hospital Operating Cost Comparison



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Overview

To compare if there is a difference in operating costs between for-profit and/or not-for-profit operators and government operators, the following cost metrics were selected:

- COL-Adjusted Operating Cost per Case Mix-Adjusted Patient Day
- COL-Adjusted Operating Cost per Case Mix-Adjusted Discharge

As it relates to the COL-Adjusted Operating Cost per Case-Mix Adjusted Patient Day and Discharge metrics, VMG reviewed the latest available data reported by the American Hospital Directory. VMG utilized total operating expenses, and subtracted bad debt, depreciation, and interest expense to arrive at total operating expenses for the Hospital and the identified peer group facilities. To further increase comparability of the results, the following adjustments were made to calculate these metrics:

- The operating expenses were adjusted for differences in case mix index ("CMI"). CMI is a measure of resource utilization, a higher case mix equates to a greater amount of resources consumed.
- VMG utilized adjusted patient days and adjusted admissions. The adjustment factor is utilized to account for the outpatient component of each hospital's patient mix.
- VMG applied a cost of living ("COL") adjustment ("COLA") to further account for the high cost of living in Key West, Florida.

Additional metrics that were considered pursuant to the operating cost comparison analysis include the following:

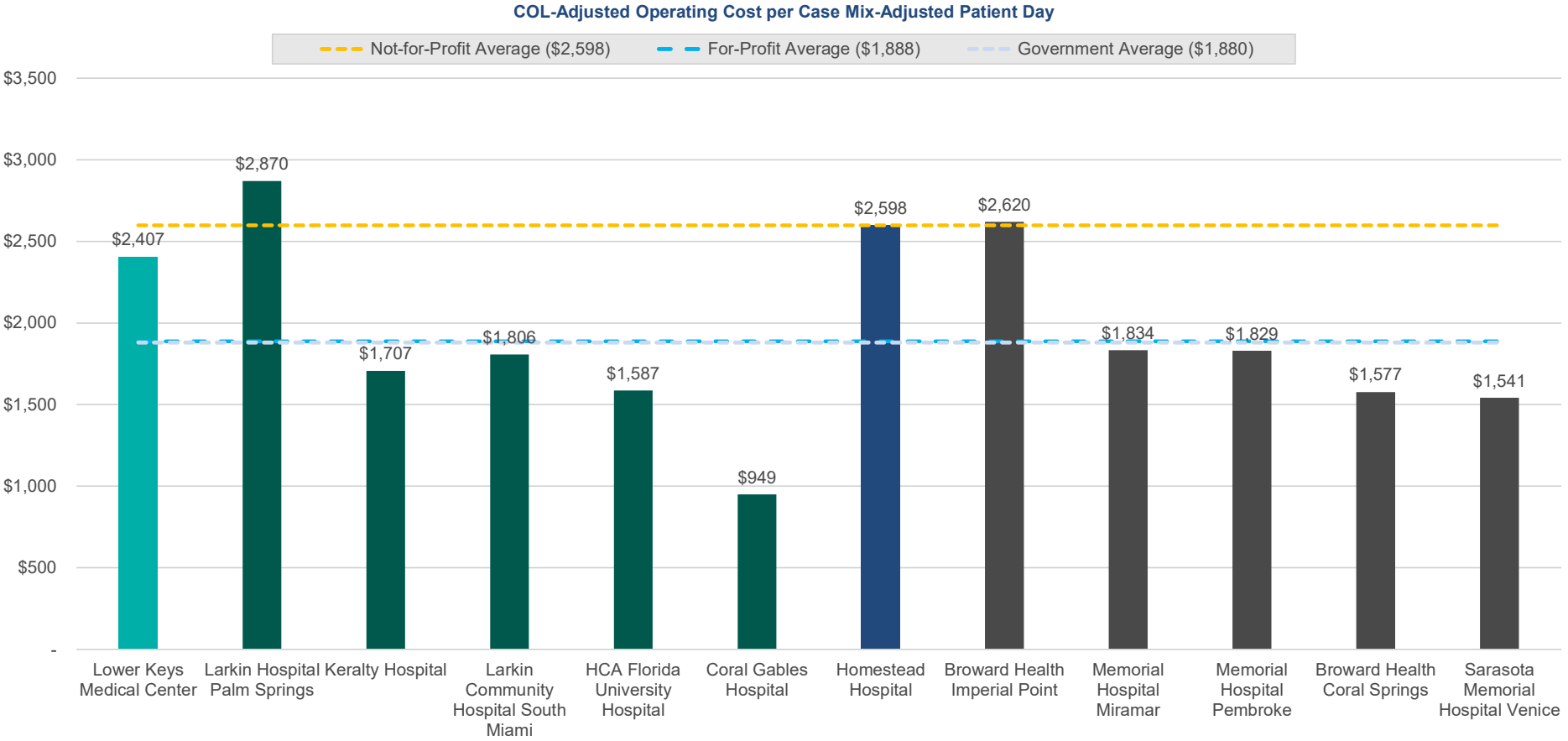
- **Operating Costs as a Percent of Total Net Operating Revenue: Indication of Resource Intensity**
- **Average Length of Stay ("ALOS"):** The hospital average length of stay ("ALOS") is a core healthcare metric measuring the average number of days an inpatient remains hospitalized. It primarily acts as an indicator of operational efficiency and resource utilization.
- **Medicare Spending per Beneficiary:** The Medicare Spending Per Beneficiary ("MSPB") measure shows whether Medicare spends more, less, or about the same on an episode of care for a Medicare patient treated in a specific inpatient hospital compared to how much Medicare spends on an episode of care across all inpatient hospitals nationally. The MSPB measure score is a ratio calculated by dividing the amount Medicare spent per patient for an episode of care initiated at a hospital by the median (or middle) amount Medicare spent per episode of care nationally. A lower ratio means that Medicare spent less per patient (i.e., a ratio that is less than 1 indicates that a hospital spends less than the national median MSPB Amount across all inpatient hospitals nationally). A ratio equal to 1 indicates that a hospital spends about the same as the national median MSPB Amount (which represents the per-episode spending level for a hospital) across all inpatient hospitals nationally. A ratio that is more than 1 indicates that a hospital spends more than the national median MSPB Amount across all inpatient hospitals nationally. The payments included in this measure are price-standardized and risk-adjusted. Price standardization removes sources of variation that are due to geographic payment differences such as wage index and geographic practice cost differences, as well as indirect medical education ("IME") or disproportionate share hospital ("DSH") payments. Risk adjustment accounts for variation due to patient age and health status.



Summary of Findings

Based on VMG's review of the operating cost metrics between for-profit/not-for profit and government hospitals, there is no definitive distinction in operating efficiency and/or performance between either types of hospital. For-profit/not-for profit operators exceed government operators in certain metrics, while government operators exceed for-profit/not-for profit operators in other metrics. It should be noted, while there are outliers, it is VMG's observation that the identified hospitals are, broadly, relatively aligned across the operating metrics reviewed. Additionally, it should be noted there are fewer district-owned hospitals in the state of Florida today than historically, which may also make comparisons difficult due to sample size. Therefore, considering all the metrics reviewed and subject to the small sample size, it is VMG's conclusion that the analysis does not reveal sufficient evidence to suggest it would be more and/or less beneficial for the Hospital to be run by a government entity than a for-profit and/or not-for-profit entity.





For-Profit and Not-for-Profit Average = \$1,989
For-Profit and Not-for-Profit Median = \$1,806

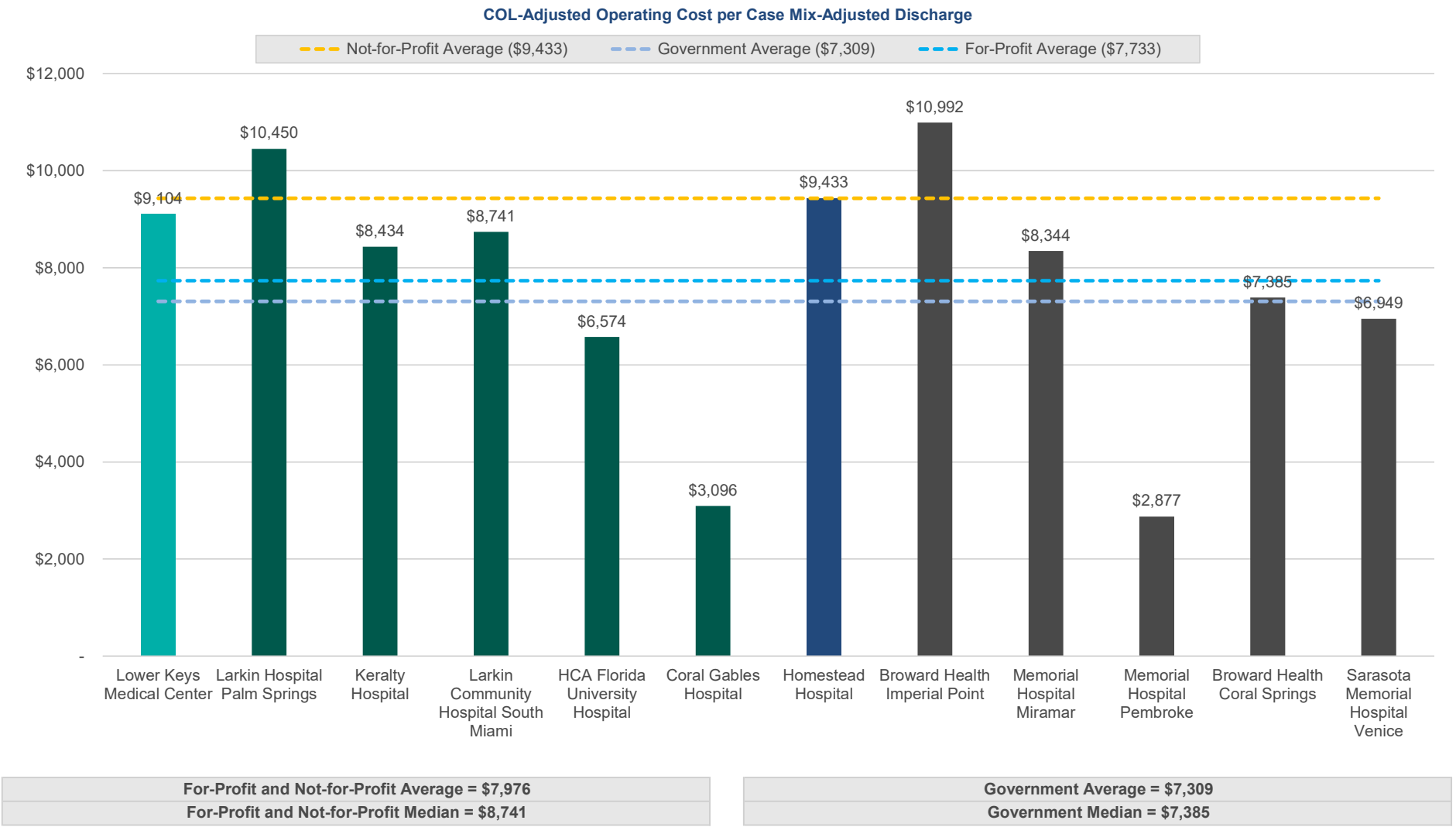
Government Average = \$1,880
Government Median = \$1,829

Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): ahd.com
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) = Operating Expenses (Excluding Depreciation, Interest, and Bad Debt) ÷ [Adjusted Discharges × CMI]



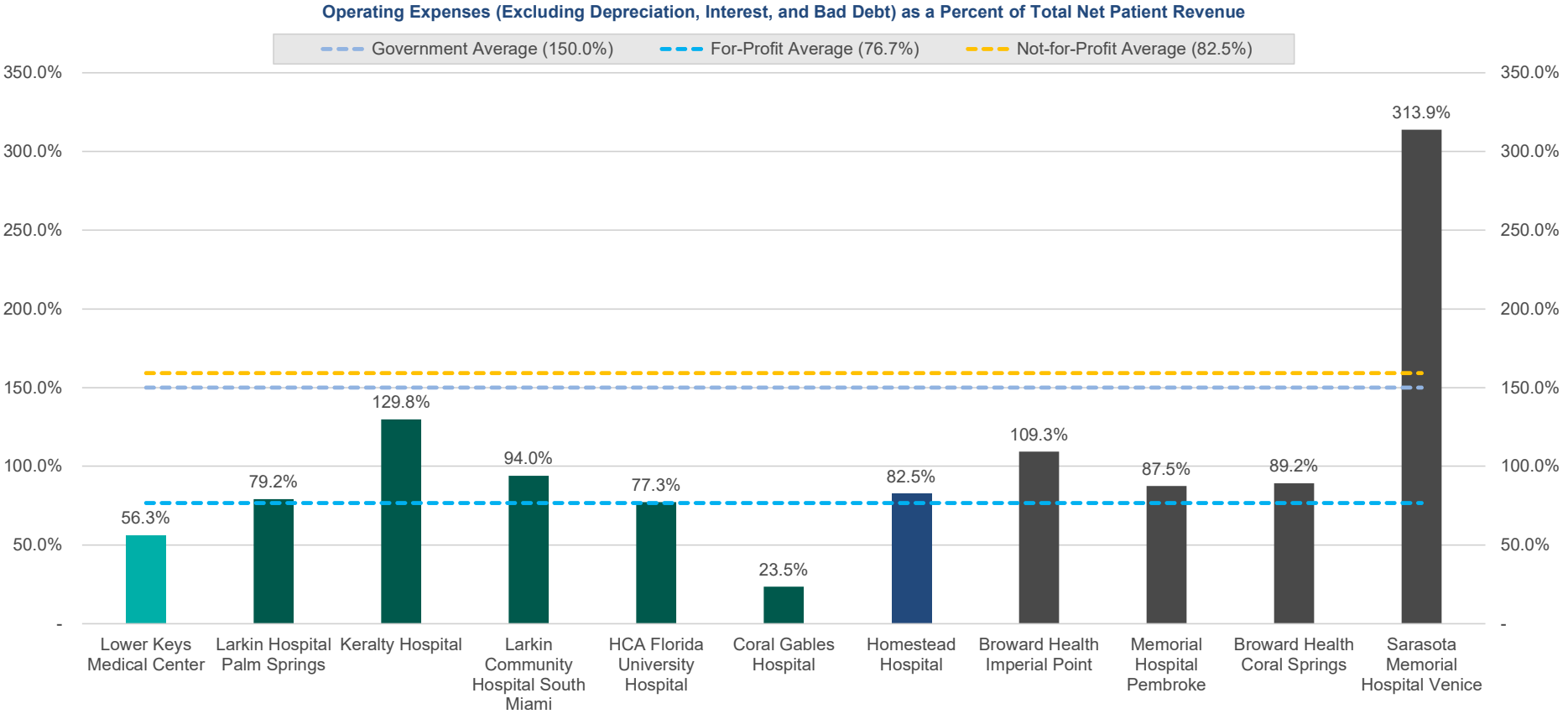


Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): ahd.com
- (2) Source(s): https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care
- (3) = Operating Expenses (Excluding Depreciation, Interest, and Bad Debt) ÷ [Adjusted Discharges × CMI]





For-Profit and Not-for-Profit Average = 77.5%
For-Profit and Not-for-Profit Median = 79.2%

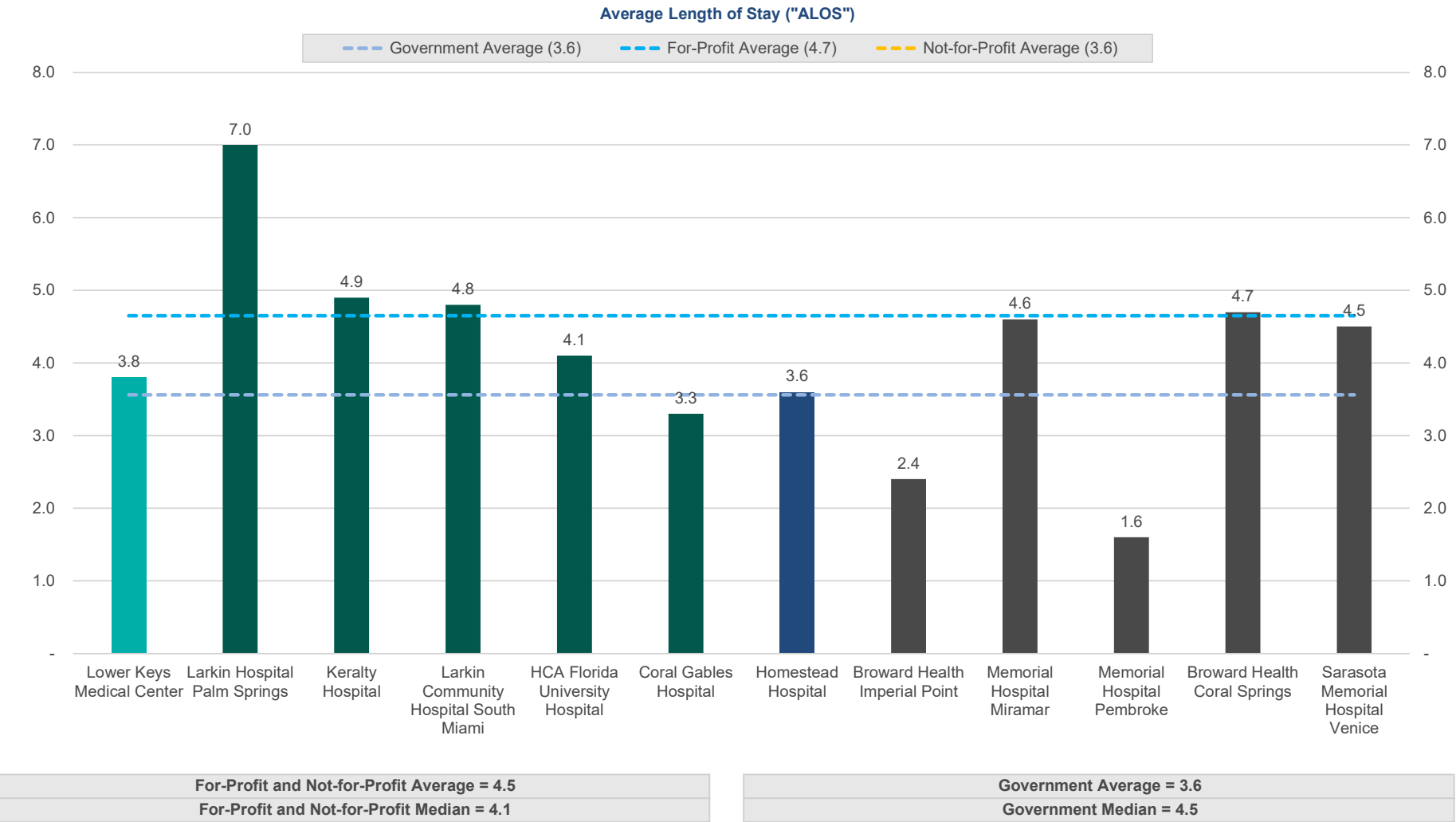
Government Average = 150.0%
Government Median = 99.3%

Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): ahd.com
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) = Operating Expenses (Excluding Depreciation, Interest, and Bad Debt) ÷ [Net Patient Revenue]



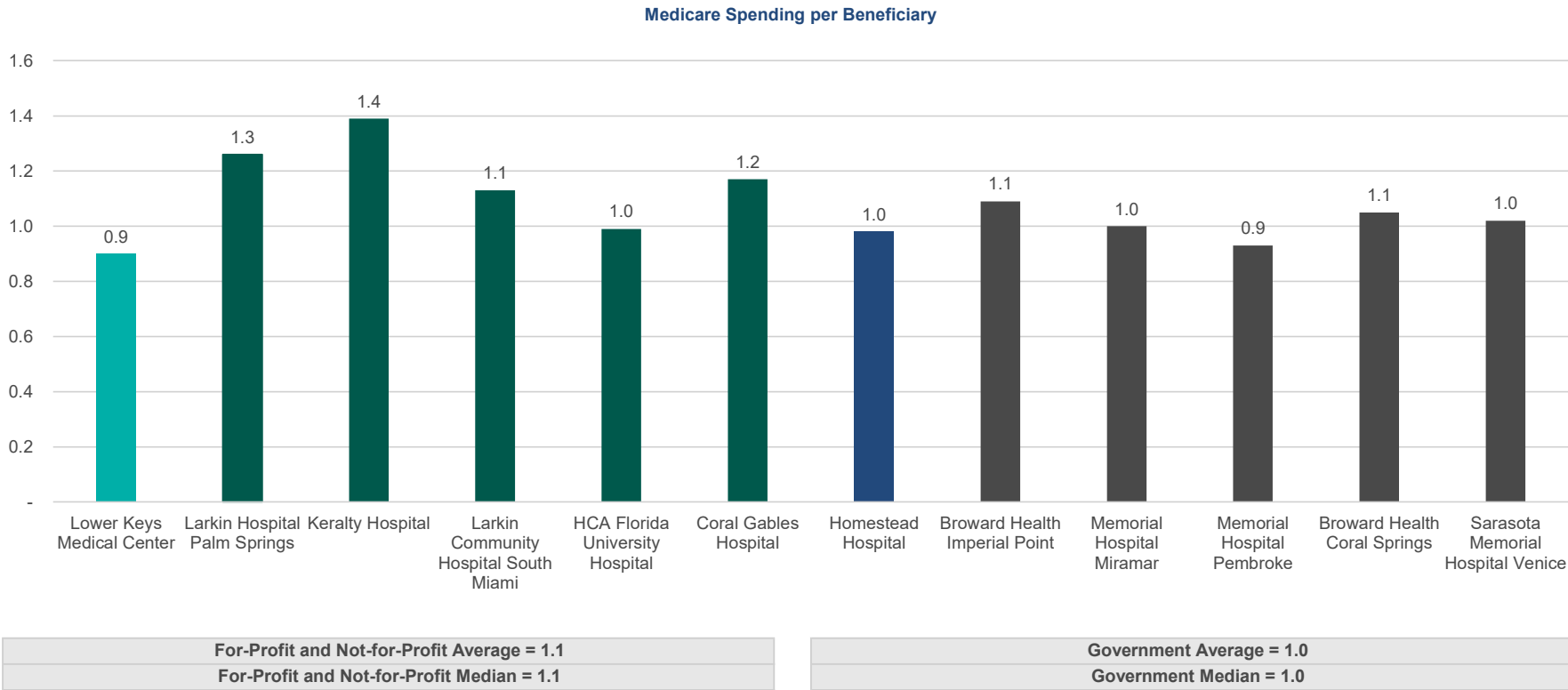


Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): ahd.com
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) The hospital average length of stay ("ALOS") is a core healthcare metric measuring the average number of days an inpatient remains hospitalized. It primarily acts as an indicator of operational efficiency and resource utilization.





Notes and Sources

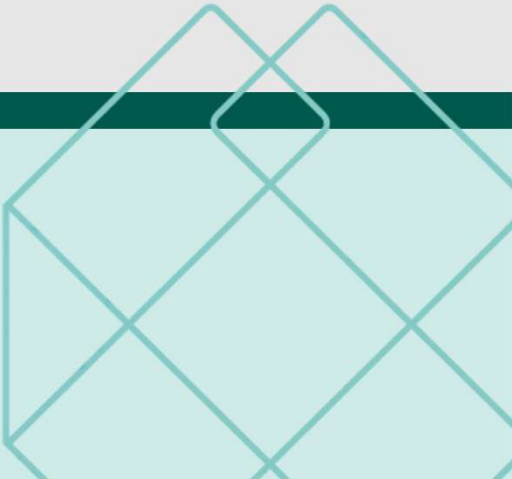
- Lower Keys Medical Center
For-Profit Hospitals
Not-for-Profit
Government Not-for-Profit
(1) Source(s): https://www.medicare.gov/care-compare/
(2) https://data.cms.gov/provider-data/topics/hospitals/payment
(3) The Medicare Spending Per Beneficiary ("MSPB" or "Medicare hospital spending per patient") measure shows whether Medicare spends more, less, or about the same on an episode of care for a Medicare patient treated in a specific inpatient hospital compared to how much Medicare spends on an episode of care across all inpatient hospitals nationally.



Final Report

Lower Keys Medical Center

Hospital Quality Comparison



Strictly Private and Confidential

Overview

As previously mentioned, according to Florida Statute § 155.40 (5)(d), VMG is required to "Consider an objective operating comparison between a hospital or health care system operated by the district, county, or municipality and other similarly situated hospitals, both not-for-profit and for-profit, which have a similar service mix, in order to determine whether there is a difference in the cost of operation using publicly available data provided by the Agency for Health Care Administration and the quality metrics identified by the Centers for Medicare and Medicaid Services Core Measures. The comparison must determine whether it is more beneficial to taxpayers and the affected community for the hospital to be operated by a governmental entity, or whether the hospital can be operated by a not-for-profit or for-profit entity with similar or better cost-efficiencies or measurable outcomes identified by the Centers for Medicare and Medicaid Services Core Measures. Additionally, CMS publishes quality measures related to psychiatric care, however, we understand that the Hospital directs the majority of its psychiatric patients to the DePoo facility, which is explicitly excluded from this analysis. Therefore, the psychiatric measures published by CMS were not considered. The following industry standard Centers for Medicare and Medicaid Services ("CMS") quality and outcomes metrics were used to compare LKMC with its selected peer group:

Ratings

- Overall Star Rating:** The overall star rating for hospitals summarizes quality information on important topics, like readmissions and deaths after heart attacks or pneumonia. The overall rating, between one (1) and five (5) stars, summarizes a variety of measures across five (5) areas of quality into a single star rating for each hospital. The five (5) measure groups include mortality, safety of care, readmission, patient experience, and timely and effective care. The overall rating shows how well each hospital performed on an identified set of quality measures compared to other hospitals in the U.S. The more stars, the better a hospital performed on the available quality measures. Some new or small hospitals may not report data on all measures, and therefore, aren't eligible for an overall hospital rating.
- Patient Survey Rating:** The hospital patient survey star rating uses a 5-star scale to make it easier for you to compare hospitals. More stars mean better quality care. The star ratings come from a patient experience of care survey called the Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") survey. The survey asks a random sample of recently discharged patients about their hospital care experience, and measures: (i) Communication with doctors; (ii) Communication with nurses; (iii) Responsiveness of hospital staff; (iv) Cleanliness of the hospital; (v) Quietness of the hospital; (vi) Communication about medicines; (vii) Discharge information; (viii) Care transition; (ix) Overall rating of hospital; and (x) Willingness to recommend hospital. Star ratings are developed for all 10 of the HCAHPS patient care experience measures. The summary star rating combines all 10 HCAHPS star ratings into one overall metric.



Quality Measures

Timely and Effective Care

The measures of timely and effective, also known as process of care measures, show how often or how quickly hospitals provide care that research shows gets the best results for patients with certain conditions, and how hospitals use outpatient medical imaging tests (like CT scans and MRIs). This information can help patients compare which hospitals give recommended care most often as part of the overall care they provide to patients.

- **Sepsis Care:** Sepsis is a complication that occurs when your body has an extreme response to an infection. It causes damage to organs in the body and can be life-threatening if not treated. Sepsis can sometimes turn into septic shock, which has a higher risk of death. Identifying sepsis early and starting appropriate care quickly increase the chances of survival.
- **Colonoscopy Follow-Up:** A colonoscopy is one test doctors can use to find precancerous polyps (abnormal growths) or colorectal cancer. Scientific evidence shows that the following measures represent best practices for follow-up colonoscopies
- **Emergency Department Care:** Timely and effective care in hospital emergency departments is essential for good patient outcomes. Delays before getting care in the emergency department can reduce the quality of care and increase risks and discomfort for patients with serious illnesses or injuries. Waiting times at different hospitals can vary widely, depending on the number of patients seen, staffing levels, efficiency, admitting procedures, or the availability of inpatient beds. The Emergency Department Care measures show how quickly hospitals treat patients who come to the hospital emergency department, compared to the average for all hospitals in the U.S. More specifically, there are five (5) Emergency Department Care-related quality measures:
 - (1) Percentage of Patients Who Left the Emergency Department Before Being Seen
 - (2) Percentage of Patients Who Came to the Emergency Department with Stroke Symptoms Who Received Brain Scan Results within 45 Minutes of Arrival. *Please note, VMG did not consider this metric as its identified peer group did not report outcomes.*
 - (3) Average (Median) Time All Patients Spent in the Emergency Department Before Leaving from the Visit, Including Psychiatric/Mental Health Patients and Patients Who were Transferred to Another Facility
 - (4) Average (Median) Time Patients Spent in the Emergency Department Before Leaving from the Visit, Excluding Patients Transferred to Another Facility or Psychiatric Care/Mental Health Patients
 - (5) Average (Median) Time Patients Spent in the Emergency Department Before Being Transferred to Another Facility, Not Including Psychiatric/Mental Health Patients
- **Healthcare Personnel Vaccination:** Hospital staff and healthcare personnel can transmit viruses to coworkers and patients, including those at higher risk for getting very sick from these viruses. To reduce the spread within a hospital, the Centers for Disease Control and Prevention ("CDC") recommends that all healthcare personnel who work in a healthcare setting get vaccinated per CDC guidelines.
- **Safe Use of Opioids:** When prescription opioids, or opioids and benzodiazepines are given at the same time, patients are at a higher risk of unintentional overdose because of the increased risk of breathing problems. Not using both types of medications at the same time reduces the risk of ER and inpatient hospital stays



- Use of Medical Imaging:** These outpatient imaging efficiency measures inform hospitals' use of medical imaging tests (like magnetic resonance images ("MRI") and computerized tomography ("CT") scans) for outpatients based on the following goals: (1) Protecting patients' safety (like keeping patients' exposure to radiation and other risks as low as possible); and, (2) Avoiding the risk, stress, and cost of doing imaging tests that patients may not need. More specifically, there are four (4) Use of Medical Imaging-related quality measures:
 - (1) Percentage of Outpatients with Low-Back Pain Who Had an MRI Without Trying Recommended Treatments (Like Physical Therapy) First
 - (2) Percentage of Outpatient CT Scans of the Abdomen That Were "Combination" (Double) Scans
 - (3) Percentage of Outpatients Who Got Cardiac Imaging Stress Tests Before Low-Risk Outpatient Surgery
 - (4) Percentage of Patients Who Had an Advanced Breast Screening on the Same Day or Within 45 Days of Their Initial Mammogram or Digital Breast Tomosynthesis ("DBT") Study

Complications and Deaths

Patients who are admitted to the hospital for treatment of medical problems sometimes get other serious injuries, complications, or conditions, and may even die. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients,.

- Complications:** These measures show serious complications that patients with Original Medicare experienced during a hospital stay or after having certain inpatient surgical procedures, and how often patients who were admitted with certain conditions died while they were in the hospital. These complications can often be prevented if hospitals follow procedures based on best practices and scientific evidence. More specifically, there are three (3) quality measures related to Complications:
 - (1) Rate of Complications for Hip/Knee Replacement Patients
 - (2) Serious Complications
- Infections:** The healthcare-associated infection ("HAI") measures are developed by the Centers for Disease Control and Prevention ("CDC") and collected through the National Healthcare Safety Network ("NHSN"). The HAI measures show how often patients in a particular hospital contract certain infections during the course of their medical treatment, when compared to similar hospitals. Many healthcare-associated infections can be prevented when hospitals use CDC-recommended infection control steps. To get payment from Medicare, hospitals are required to report data about some infections to the CDC's NHSN. The public reporting of these data is part of a movement by the Department of Health and Human Services to make healthcare safer. More specifically, the quality measures related to "Infections" include:
 - (1) Catheter-Associated Urinary Tract Infections ("CAUTI") in ICUs and Select Wards
 - (2) Surgical Site Infections ("SSI") from Colon Surgery
 - (3) Clostridium Difficile (C.diff.) Intestinal Infections



- **Death Rates:** Deaths (mortality) rates show how often patients die within 30 days of admission to the hospital. Deaths can be for any reason and can occur in the hospital or after discharge. Death rates are measured within 30 days because deaths after a longer time period may have less to do with the care the hospital provided and more to do so with other complicating illnesses, patients' own behavior, or other case services received after they leave the hospital. More specifically, quality measures related to "Death Rates" include the following:

- (1) Death Rate for Patients (Hospital-Wide)
- (2) Death Rate for COPD Patients
- (3) Death Rate for Heart Failure Patients
- (4) Death Rate for Pneumonia Patients

Unplanned Hospital Visits

Returning to the hospital for unplanned care disrupts patients' lives, increases their risk of harmful events like healthcare-associated infections, and costs more money. Hospitals that give high quality care can keep patients from returning to the hospital and reduce their stay length if they have to come back.

- **Rates of Readmission:** How often patients return to the hospital soon after being discharged
 - (1) Rate of Readmission After Discharge from Hospital (Hospital-Wide)
 - (2) Rate of Readmission for Chronic Obstructive Pulmonary Disease ("COPD")
 - (3) Rate of Readmission for Heart Failure Patients
 - (4) Rate of Readmission for Pneumonia Patients
 - (5) Rate of Readmission After Knee/Hip Replacement
- **Measures of Unplanned Hospital Visits After Outpatient Procedures:** How often patients visit the hospital (in the emergency department, under observation, or in an inpatient hospital unit) after an outpatient procedure.
 - (1) Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy
 - (2) Ratio of Unplanned Hospital Visits After Hospital Outpatient Surgery



- **Hospital Return Days:** The average number of days patients who are hospitalized for certain conditions spend back in the hospital (in the emergency department, under observation, or in an inpatient hospital unit) soon after they are discharged.

(1) Hospital Return Days for Heart Failure Patients

(2) Hospital Return Days for Pneumonia Patients

Notes and Sources

- (1) Source(s): <https://www.cms.gov/medicare/quality/measures/core-measures>
- (2) Source(s): <https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative>



Summary of Findings

Based on VMG's review of the quality metrics between for-profit/not-for profit and government hospitals, there is no definitive distinction in the quality of care provided by either types of hospital. For-profit/not-for profit operators exceed government operators in certain metrics, while government operators exceed for-profit/not-for profit operators in other metrics. It should be noted, while there are outliers, it is VMG's observation that the identified hospitals are, broadly, relatively aligned across the quality metrics reviewed. Additionally, it should be noted there are few district-owned hospitals in the state of Florida today than historically, which may also make comparisons difficult due to sample size. Therefore, considering all the metrics reviewed and subject to the small sample size, it is VMG's conclusion that the analysis does not reveal sufficient evidence to suggest it would be more and/or less beneficial for the Hospital to be run by a government entity than a for-profit and/or not-for-profit entity.

Comparison of Averages		Median of Peer Group Hospitals		Average of Peer Group Hospitals	
		For-Profit/Not-for-Profit	Government	For-Profit/Not-for-Profit	Government
Star Ratings					
Overall Hospital Quality Star Rating	Higher is Better	3.0	4.0	3.0	4.2
Inpatient Patient Survey Rating	Higher is Better	3.0	4.0	2.8	3.4
Nurse Communication	Higher is Better	77.0%	80.0%	77.0%	77.6%
Doctor Communication	Higher is Better	78.0%	75.0%	78.7%	77.0%
Staff Explanation of Medicines	Higher is Better	56.0%	61.0%	57.9%	59.2%
Room and Bathroom Cleanliness	Higher is Better	81.0%	77.0%	81.4%	81.4%
Quietness	Higher is Better	61.0%	64.0%	61.1%	62.6%

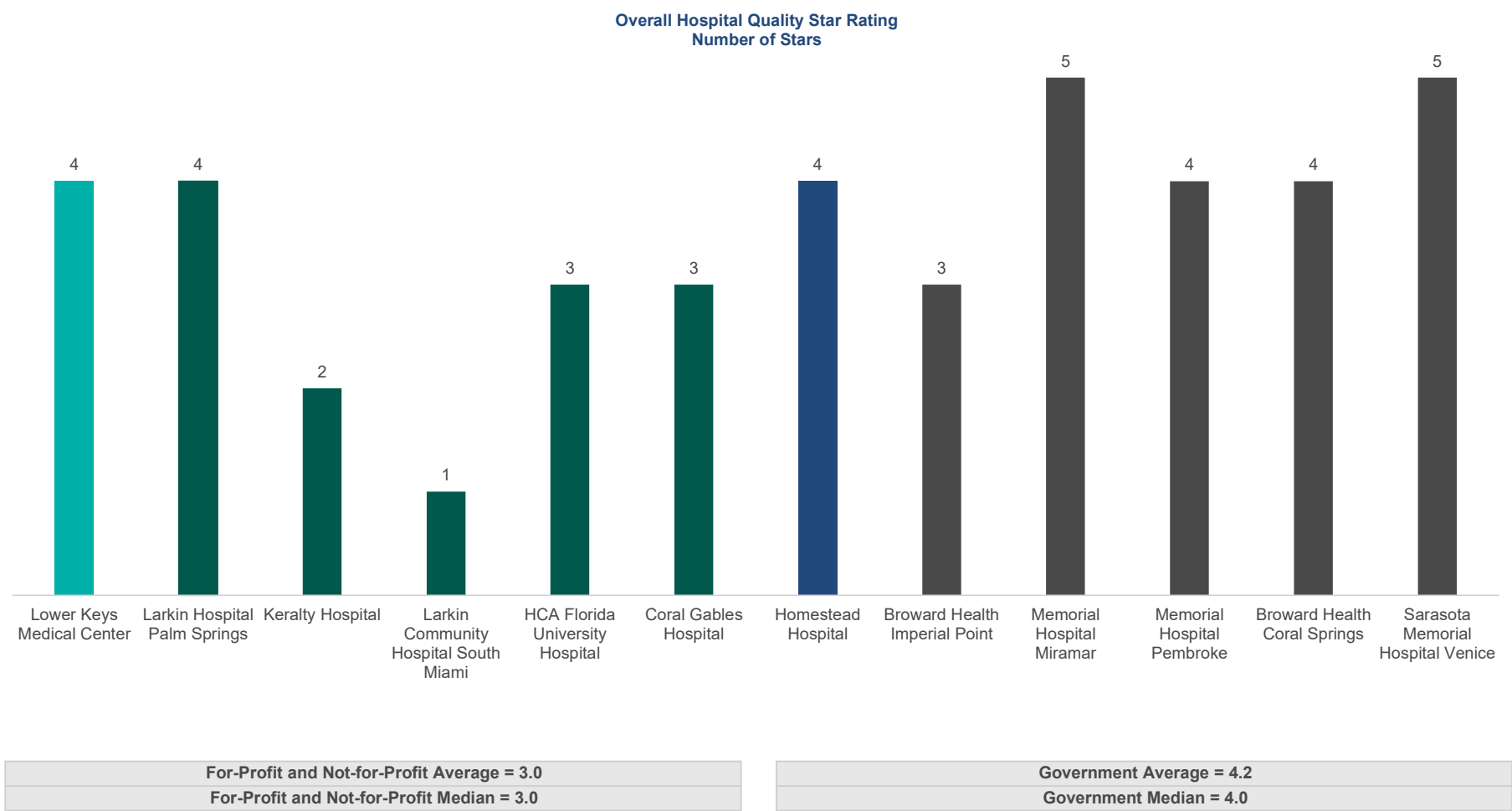


Comparison of Averages		Median of Peer Group Hospitals		Average of Peer Group Hospitals	
		For-Profit/Not-for-Profit	Government	For-Profit/Not-for-Profit	Government
Quality Measures					
Timely and Effective Care Measures					
Percentage of Patients Who Received Appropriate Care for Severe Sepsis or Septic Shock	Higher is Better	78.0%	77.0%	80.7%	80.8%
Percentage of Patients Receiving Appropriate Recommendation for Follow-Up Screening Colonoscopy	Higher is Better	100.0%	98.0%	99.6%	97.8%
Emergency Department Care					
Percentage of Patients Who Left the Emergency Department Before Being Seen	Lower is Better	1.5%	1.0%	1.5%	1.0%
Average (Median) Time All Patients Spent in the Emergency Department Before Leaving from the Visit, Including Psychiatric/Mental Health Patients and Patients Who Were Transferred to Another Facility	Lower is Better	155	164	174	173
Average (Median) Time Patients Spent in the Emergency Department Before Leaving from the Visit, Excluding Psychiatric/Mental Health Patients and Patients Who Were Transferred to Another Facility	Lower is Better	148	162	166	166
Average (Median) Time Patients Spent in the Emergency Department Before Being Transferred to Another Facility, Not Including Psychiatric/Mental Health Patients	Lower is Better	280	280	273	273
Percentage of Healthcare Workers Given Influenza Vaccination	Higher is Better	45.0%	81.0%	49.7%	74.2%
Safe Use of Opioids	Lower is Better	7.0%	15.0%	7.7%	15.4%
Use of Medical Imaging					
Percentage of Outpatient Computer Tomography ("CT") Scans of the Abdomen That Were "Combination" (Double) Scans	Lower is Better	4.7%	6.3%	6.3%	6.2%
Percentage of Outpatients Who Got Cardiac Imaging Stress Tests Before Low-Risk Outpatient Surgery	Lower is Better	3.8%	5.6%	3.8%	5.6%
Percentage of Patients Who Had an Advanced Breast Screening on the Same Day or Within 45 Days of Their Initial Mammogram or Digital Breast Tomosynthesis ("DBT") Study	Between 5.0% and 12.0% is favorable	18.1%	34.5%	18.1%	31.0%



Comparison of Averages		Median of Peer Group Hospitals		Average of Peer Group Hospitals	
		For-Profit/Not-for-Profit	Government	For-Profit/Not-for-Profit	Government
Complications, Infections, and Deaths					
Complications: Rate of Complications for Hip/Knee Replacement Patients	Lower is Better	3.8%	2.8%	3.8%	2.8%
Complications: Serious Complications	Lower is Better	0.93	0.95	0.97	0.89
Infections: Catheter-Associated Urinary Tract Infections ("CAUTI") in ICUs and Select Wards	Lower is Better	0.37	0.79	0.45	0.74
Infections: Surgical Site Infections ("SSI") from Colon Surgery	Lower is Better	0.36	1.09	0.64	0.94
Infections: Clostridium Difficile ("C.diff.") Intestinal Infections	Lower is Better	0.18	0.34	0.28	0.28
Death Rates (Overall)	Lower is Better	4.2%	3.9%	4.3%	3.9%
Death Rates by Medical Condition: Chronic Obstructive Pulmonary Disease ("COPD")	Lower is Better	8.4%	8.6%	8.4%	8.5%
Death Rates by Medical Condition: Heart Failure	Lower is Better	9.8%	10.4%	10.2%	10.3%
Death Rates by Medical Condition: Pneumonia	Lower is Better	13.7%	14.9%	14.0%	15.4%
Unplanned Hospital Visits					
Unplanned Hospital Visits: Rate of Readmission After Discharge from Hospital (Hospital-Wide)	Lower is Better	15.8%	15.2%	15.9%	15.1%
Unplanned Hospital Visits by Medical Condition: Rate of Readmission for Chronic Obstructive Pulmonary Disease ("COPD") Patients	Lower is Better	18.1%	17.9%	18.1%	18.3%
Unplanned Hospital Visits by Medical Condition: Rate of Readmission for Heart Failure Patients	Lower is Better	19.9%	19.6%	19.9%	19.9%
Unplanned Hospital Visits by Medical Condition: Hospital Return Days for Heart Failure Patients (Average Days per 100 Discharges)	Lower is Better	3.50	-8.50	21.08	-4.58
Unplanned Hospital Visits by Medical Condition: Rate of Readmission for Pneumonia Patients	Lower is Better	15.5%	16.2%	16.0%	15.9%
Unplanned Hospital Visits by Medical Condition: Hospital Return Days for Pneumonia Patients (Average Days per 100 Discharges)	Lower is Better	-2.80	23.60	12.84	15.36
Unplanned Hospital Visits by Procedure: Rate of Readmission After Hip/Knee Replacement	Lower is Better	4.4%	4.6%	4.4%	4.6%
Unplanned Hospital Visits by Procedure: Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy (per 1,000 Colonoscopies)	Lower is Better	13.20	13.70	13.20	13.58
Unplanned Hospital Visits by Procedure: Rate of Unplanned Hospital Visits After Hospital Outpatient Surgery	Lower is Better	1.00	1.00	1.03	1.00





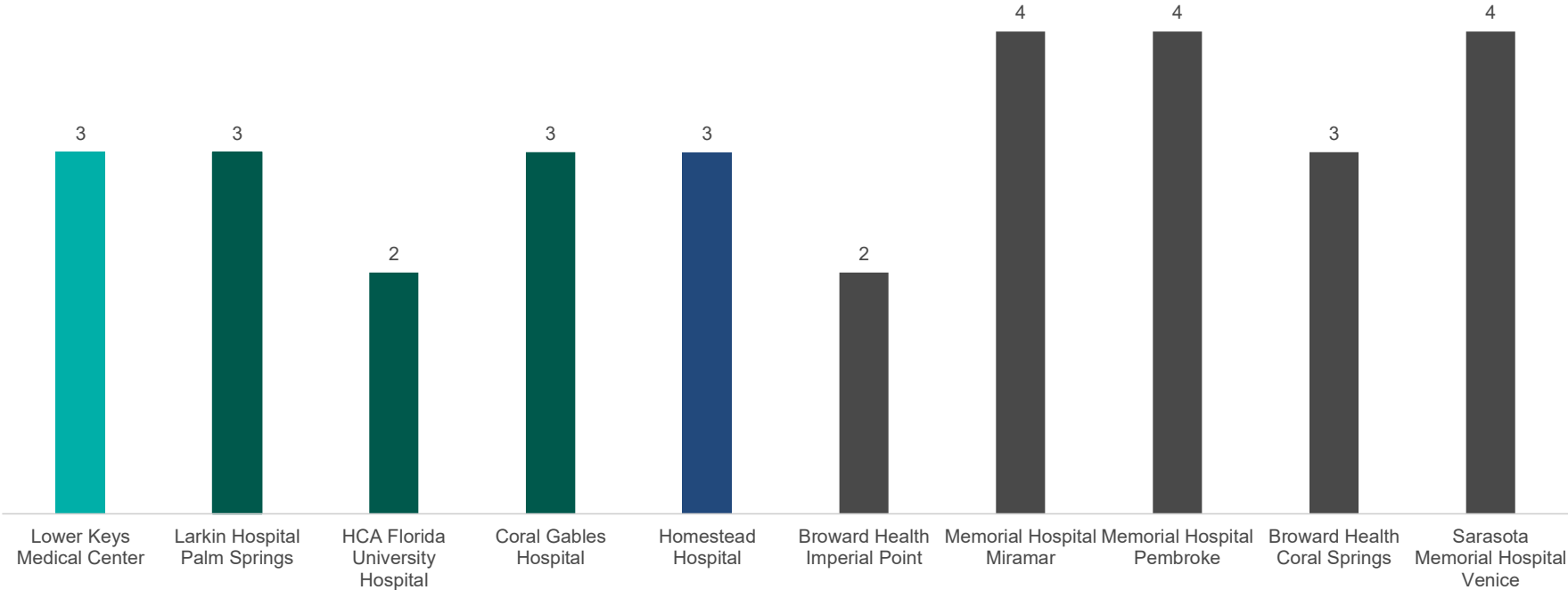
Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) The Overall Hospital Quality Star Rating ("Overall Star Rating") summarizes a variety of measures across five (5) areas of quality into a single star rating for each hospital. Once reporting thresholds are met, a hospital's Overall Star Rating is calculated using only those measures for which data are available. Hospitals report data to the Centers for Medicare & Medicaid Services ("CMS") through the Hospital Inpatient Quality Reporting ("IQR") Program, Hospital Outpatient Quality Reporting ("OQR") Program, Hospital Readmission Reduction Program ("HRRP"), Hospital-Acquired Condition ("HAC") Reduction Program, and Hospital Value-Based Purchasing ("VBP") Program.



Inpatient Patient Survey Rating
Number of Stars



For-Profit and Not-for-Profit Average = 2.8
For-Profit and Not-for-Profit Median = 3.0

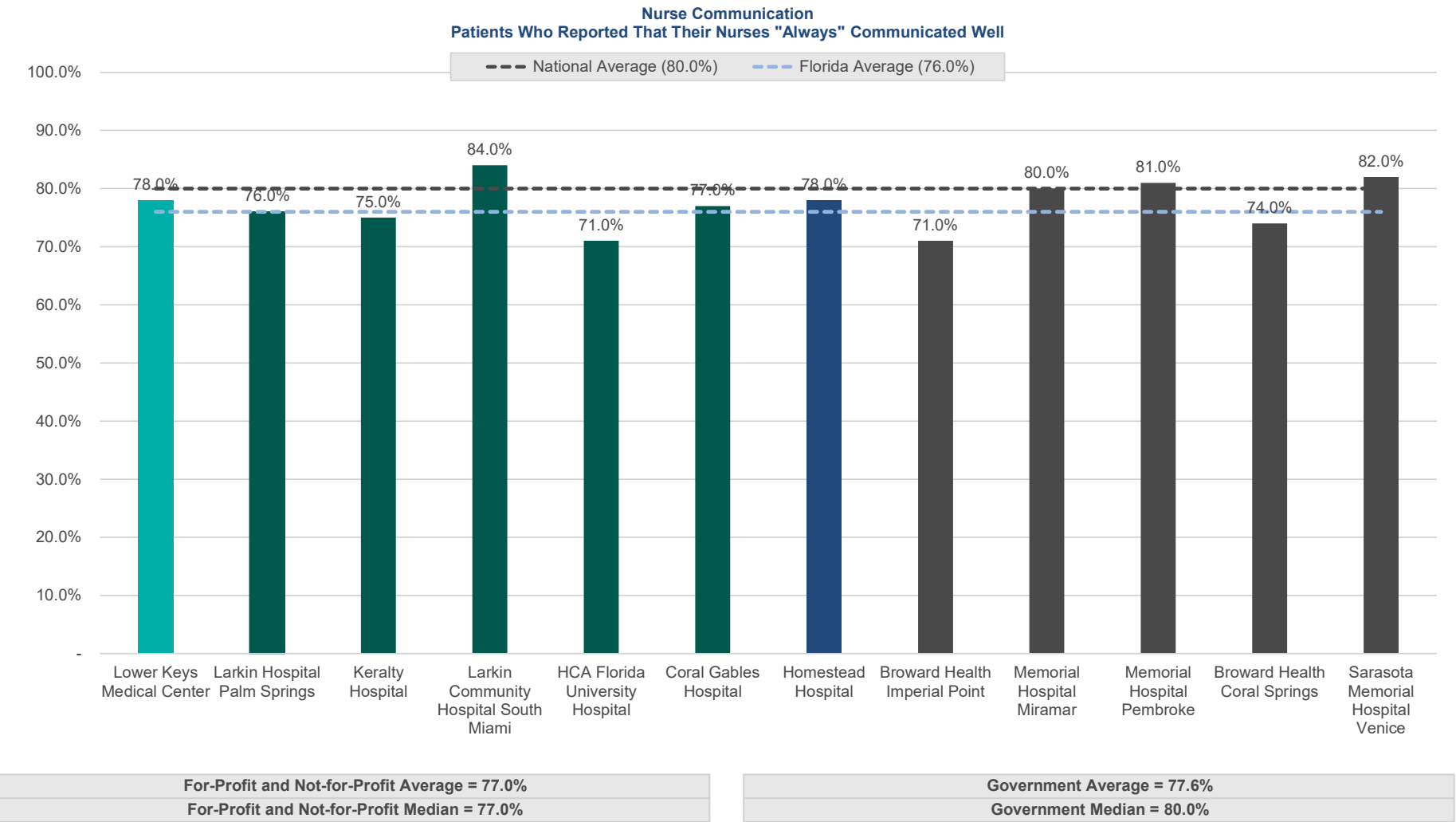
Government Average = 3.4
Government Median = 4.0

Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) The patient survey rating measures patients' experiences of their care. Recent patients were asked about important topics like how well nurses and doctors communicated and treated patients, and how well staff prepared patients to recover at home, and the cleanliness of the facility.



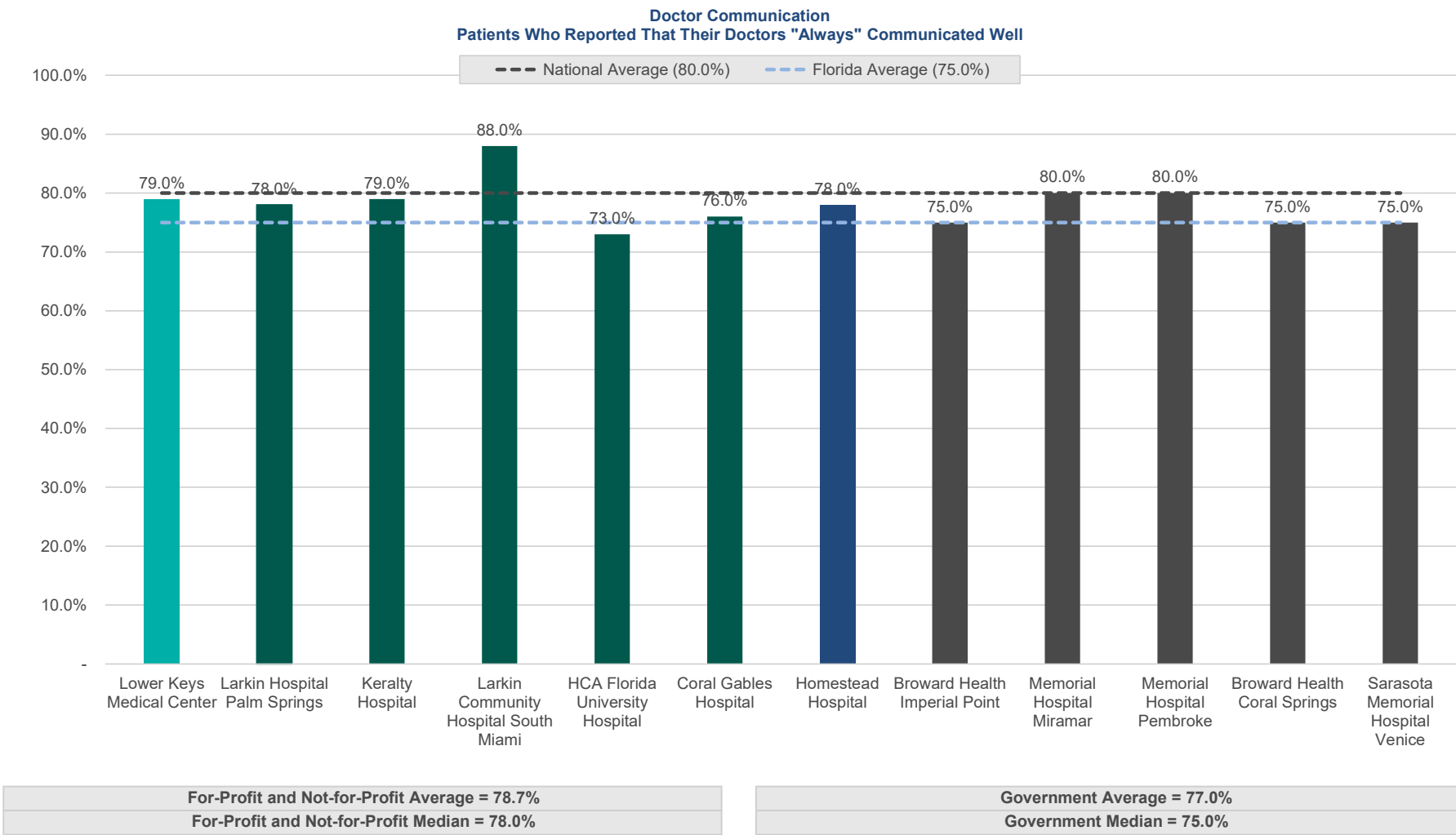


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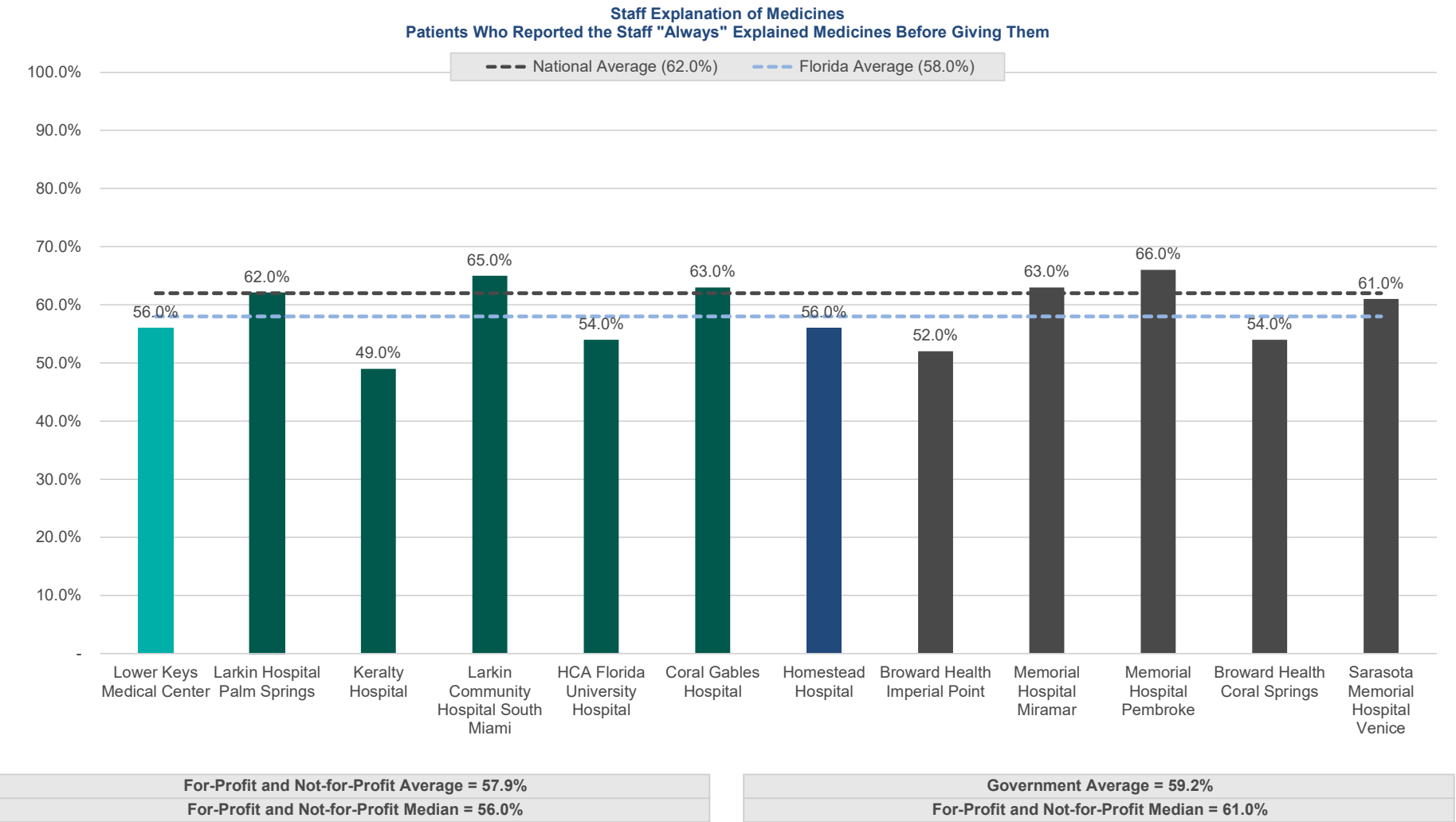


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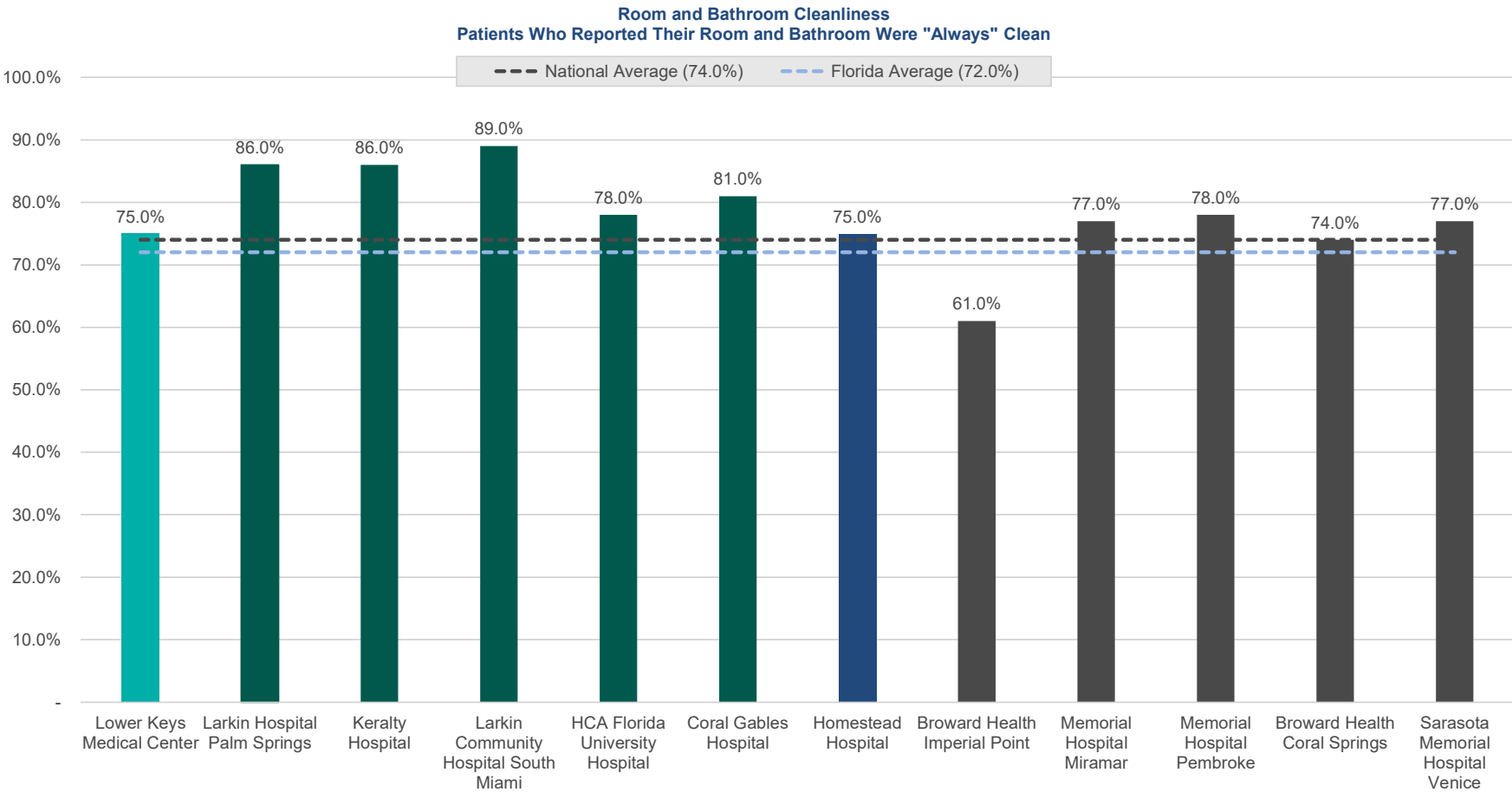




Notes and Sources

- Lower Keys Medical Center For-Profit Hospitals Not-for-Profit Government Not-for-Profit
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- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) The patient survey rating measures patients' experiences of their care. Recent patients were asked about important topics like how well nurses and doctors communicated and treated patients, and how well staff prepared patients to recover at home, and the cleanliness of the facility.





For-Profit and Not-for-Profit Average = 81.4%
For-Profit and Not-for-Profit Median = 81.0%

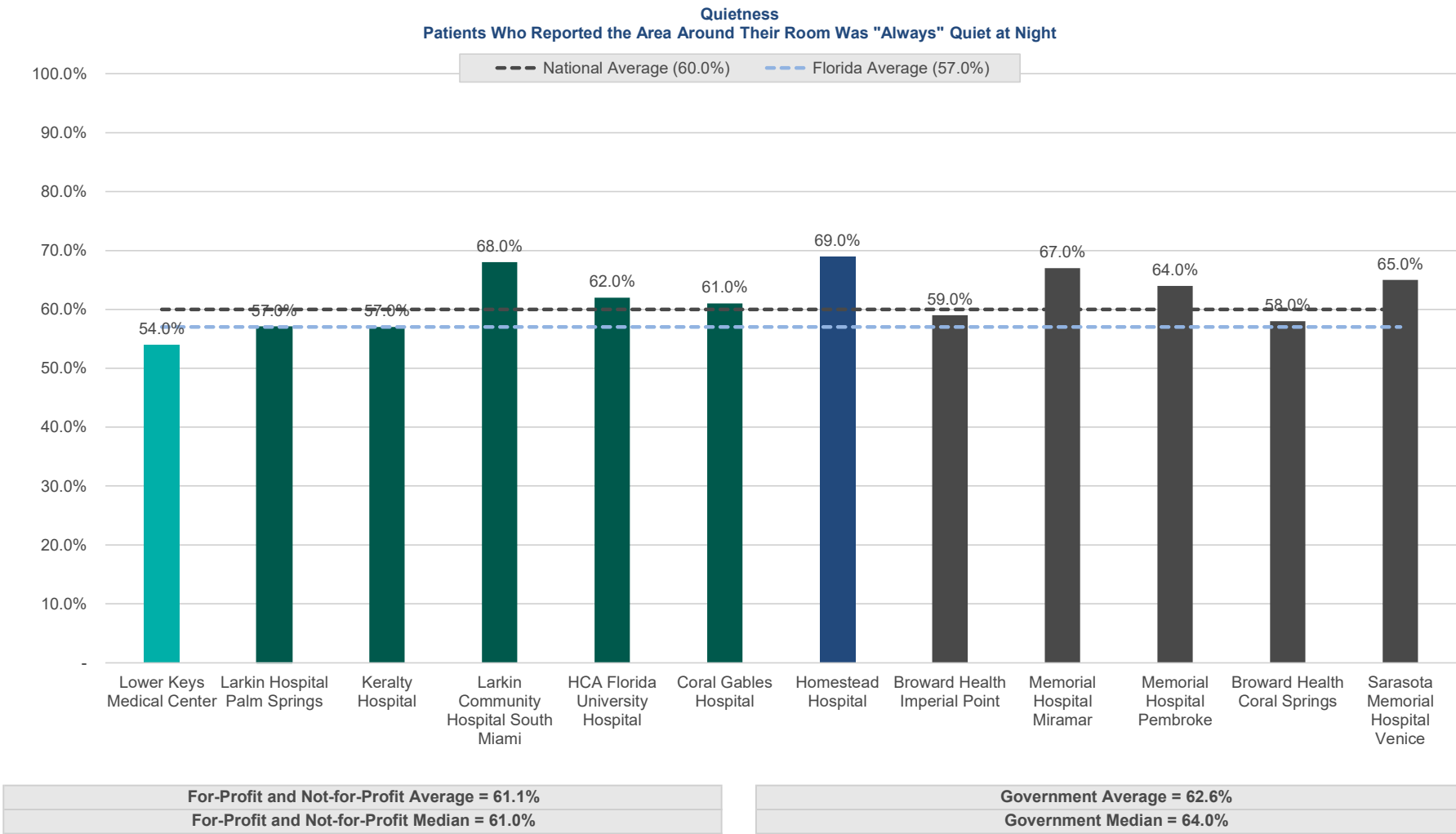
Government Average = 73.4%
Government Median = 77.0%

Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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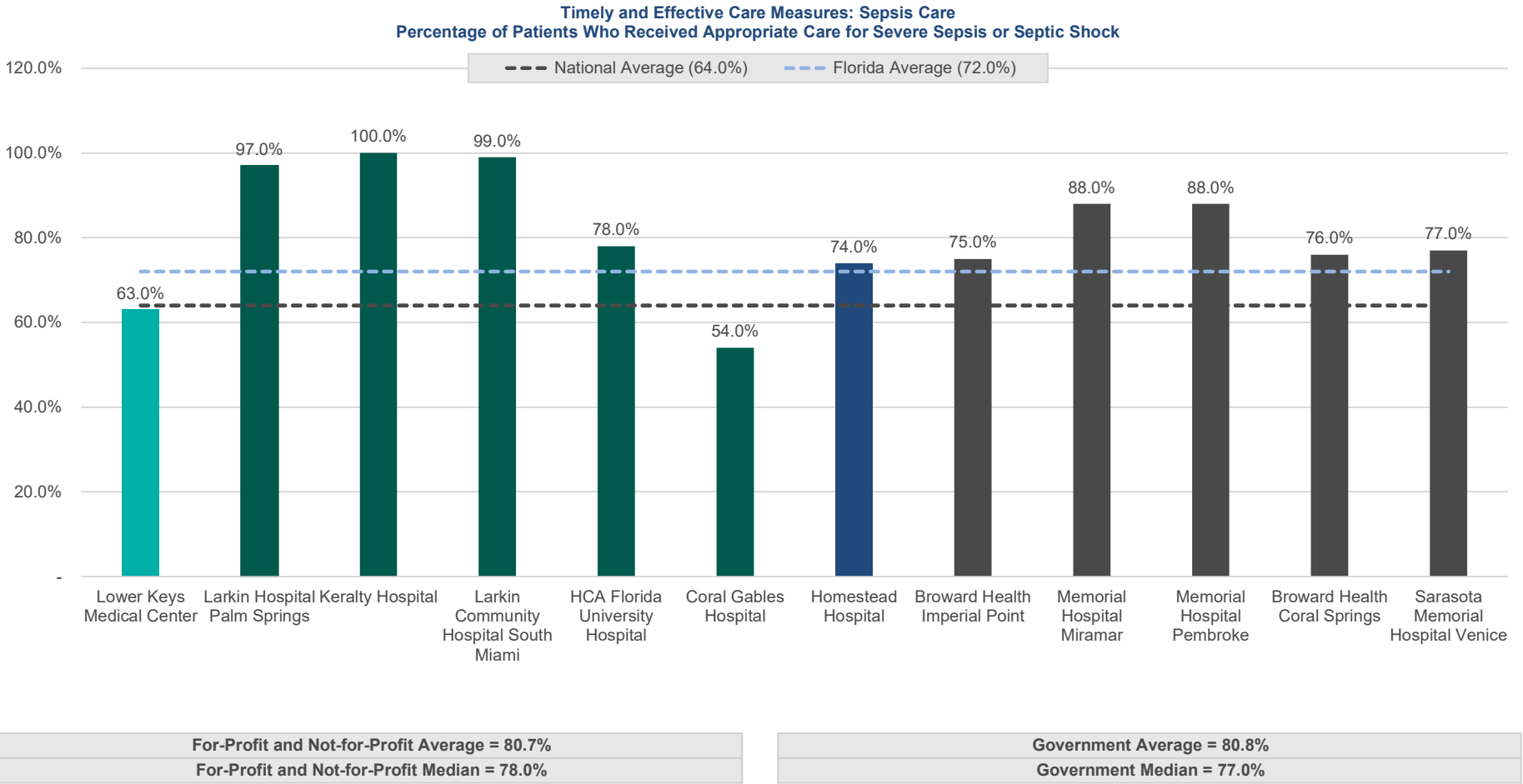


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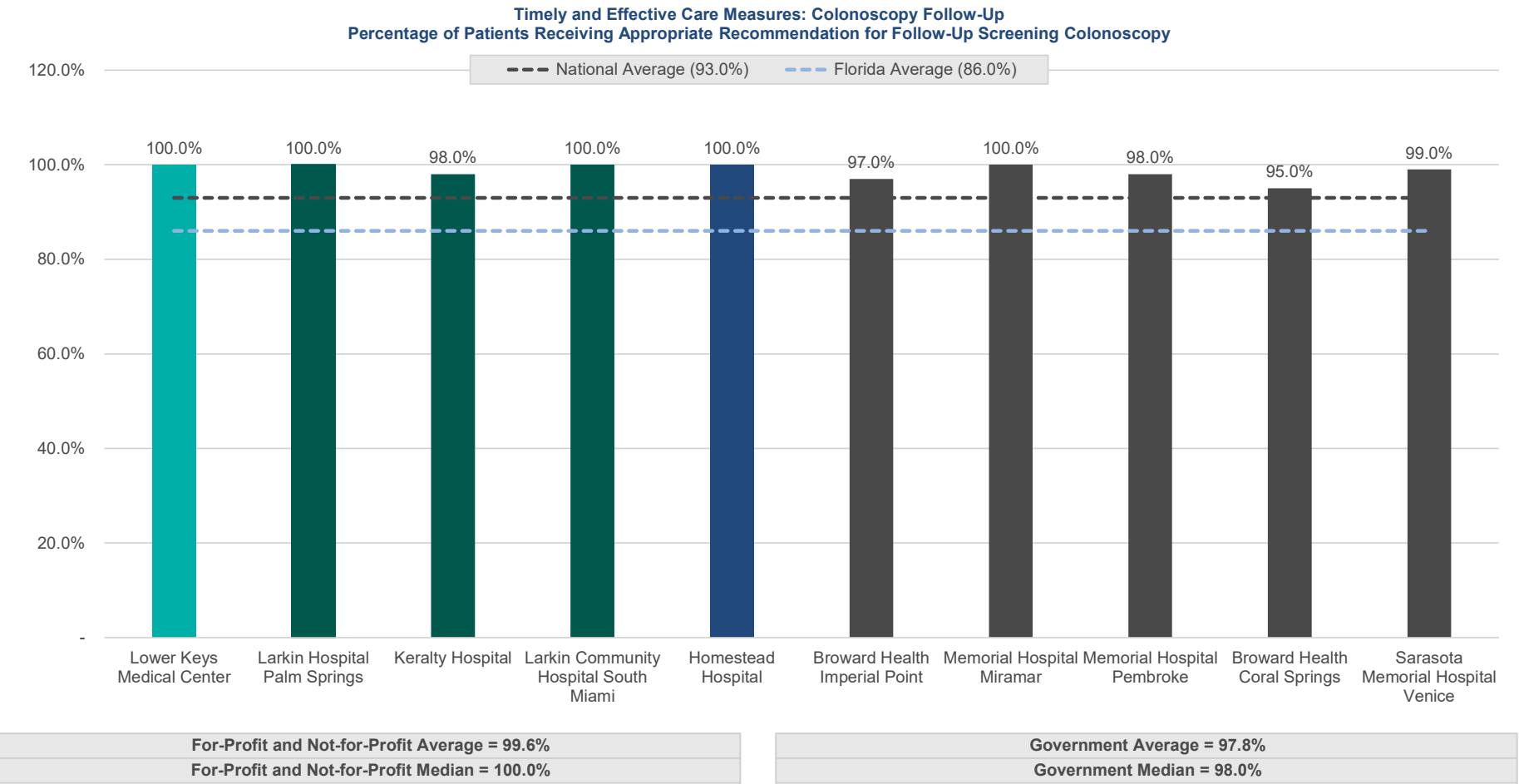


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Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) Sepsis is a complication that occurs when a patient has an extreme response to an infection. It causes damage to organs in the body and can be life-threatening if not treated. If sepsis becomes severe enough or develops into septic shock, the chances of dying increase significantly. On average over 350,000 people in the United States die every year from sepsis. Anyone can develop sepsis, but older adults and people with weak immune systems have a higher risk for developing sepsis and a greater chance of dying from severe sepsis or septic shock. Best practice guidelines show that early identification of sepsis and early appropriate care can lower the risk of death from sepsis. This measure shows the percentage of patients with severe sepsis or septic shock for which a hospital provides appropriate care. Higher percentages are better.

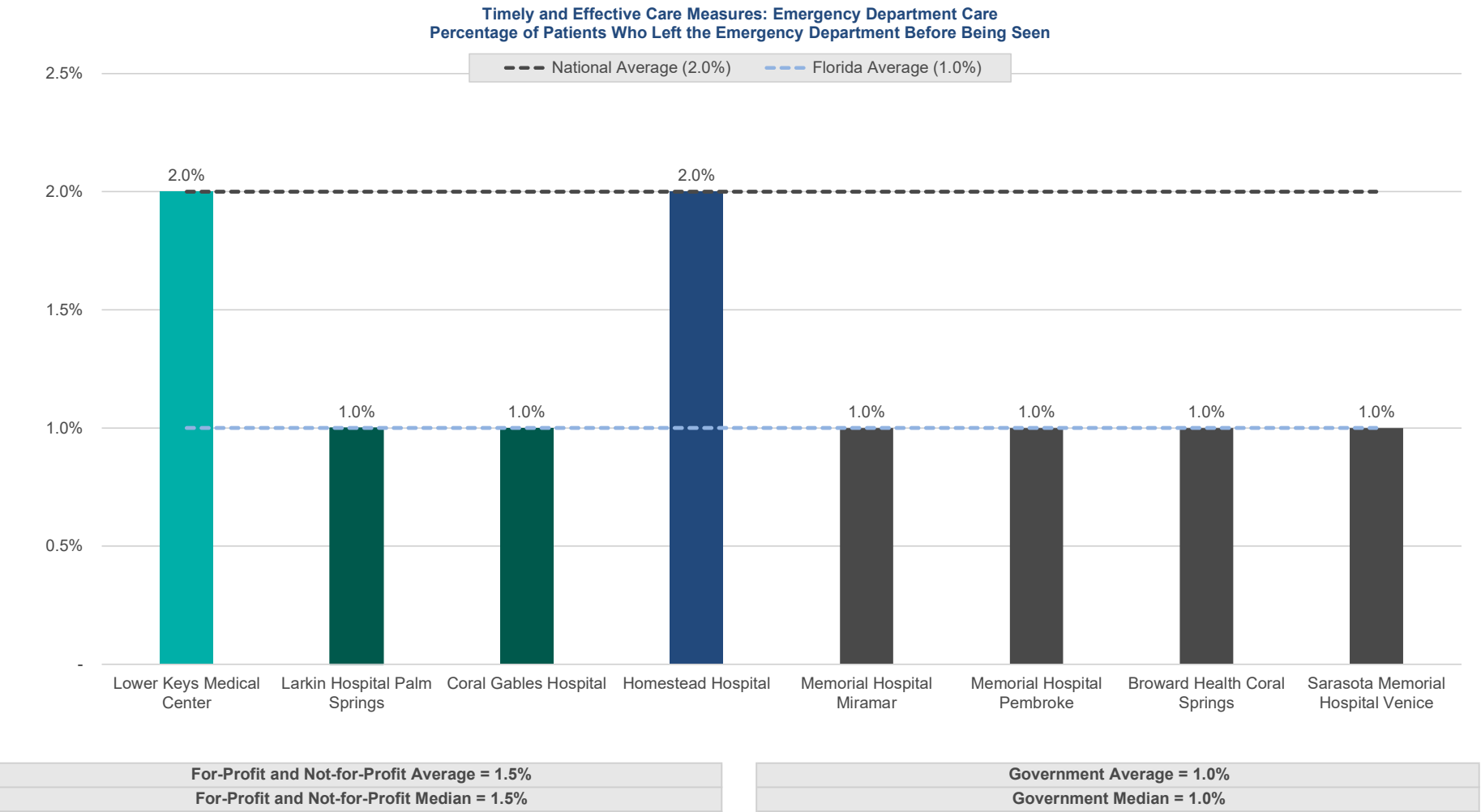




Notes and Sources

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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) This measure shows the percentage of patients aged 45 to 75 years whose colonoscopy did not require removal of a polyp or a biopsy and who received a recommendation for having their next follow-up colonoscopy in 10 years. The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer beginning at age 45. A colonoscopy is one test doctors can use to find precancerous polyps (abnormal growths) or colorectal cancer. During a colonoscopy, your doctor can remove any polyps that are found. Individuals between the ages of 45 and 75 who are not at high risk should have a screening colonoscopy every 10 years. Regular screening colonoscopies are not recommended for most people over 75 years of age, because the benefits of having colonoscopies are small compared to the potential risks. Higher percentages are better.

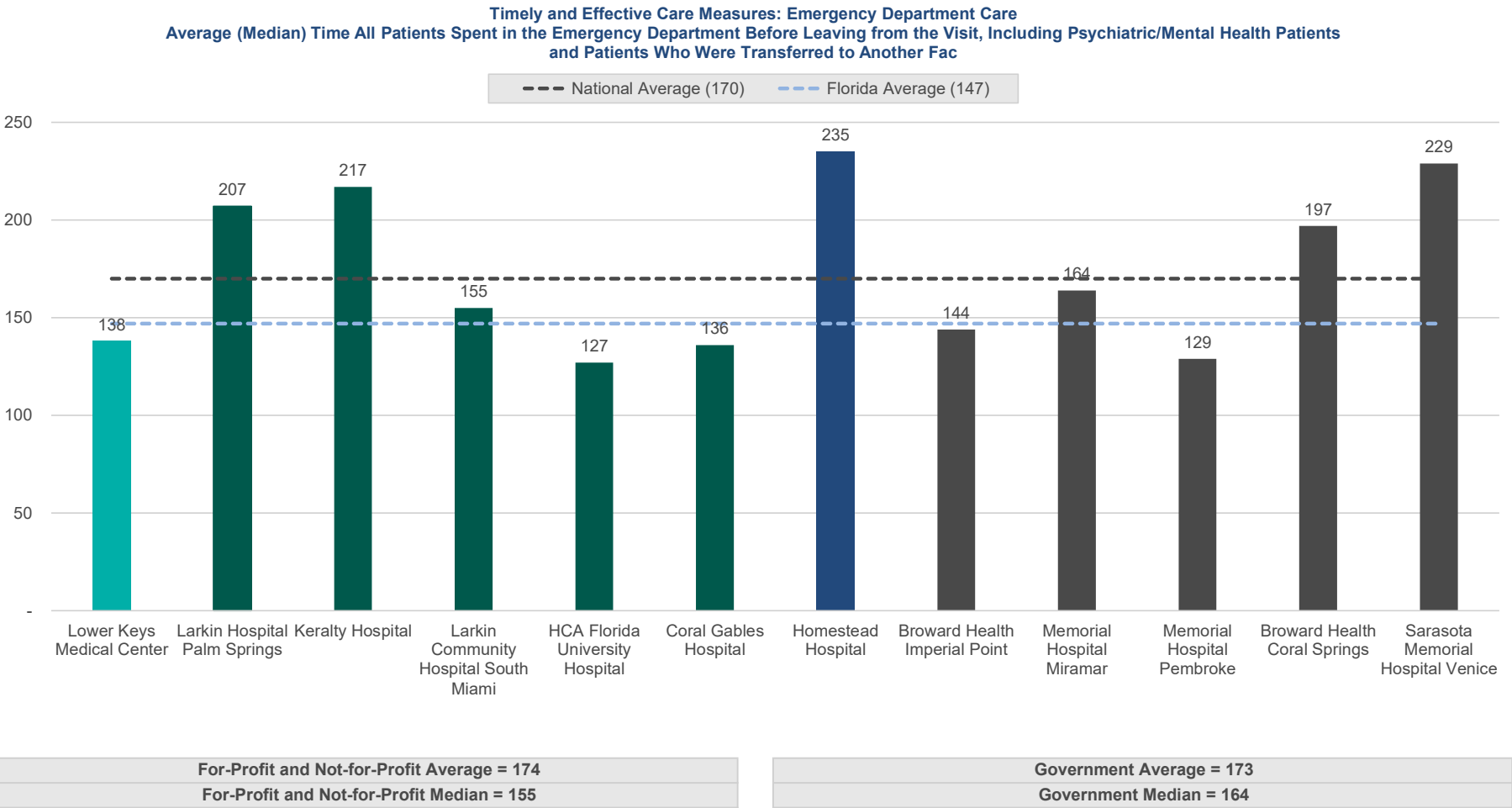




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- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) This measure shows the percentage of all individuals who signed into an emergency department but left before being evaluated by a healthcare professional. Hospital emergency departments that have high percentages of patients who leave without being seen may not have the staff or resources to provide timely and effective emergency room care. Patients who leave the emergency department without being seen may be seriously ill, putting themselves at higher risk for poor health outcomes. Lower percentages are better.

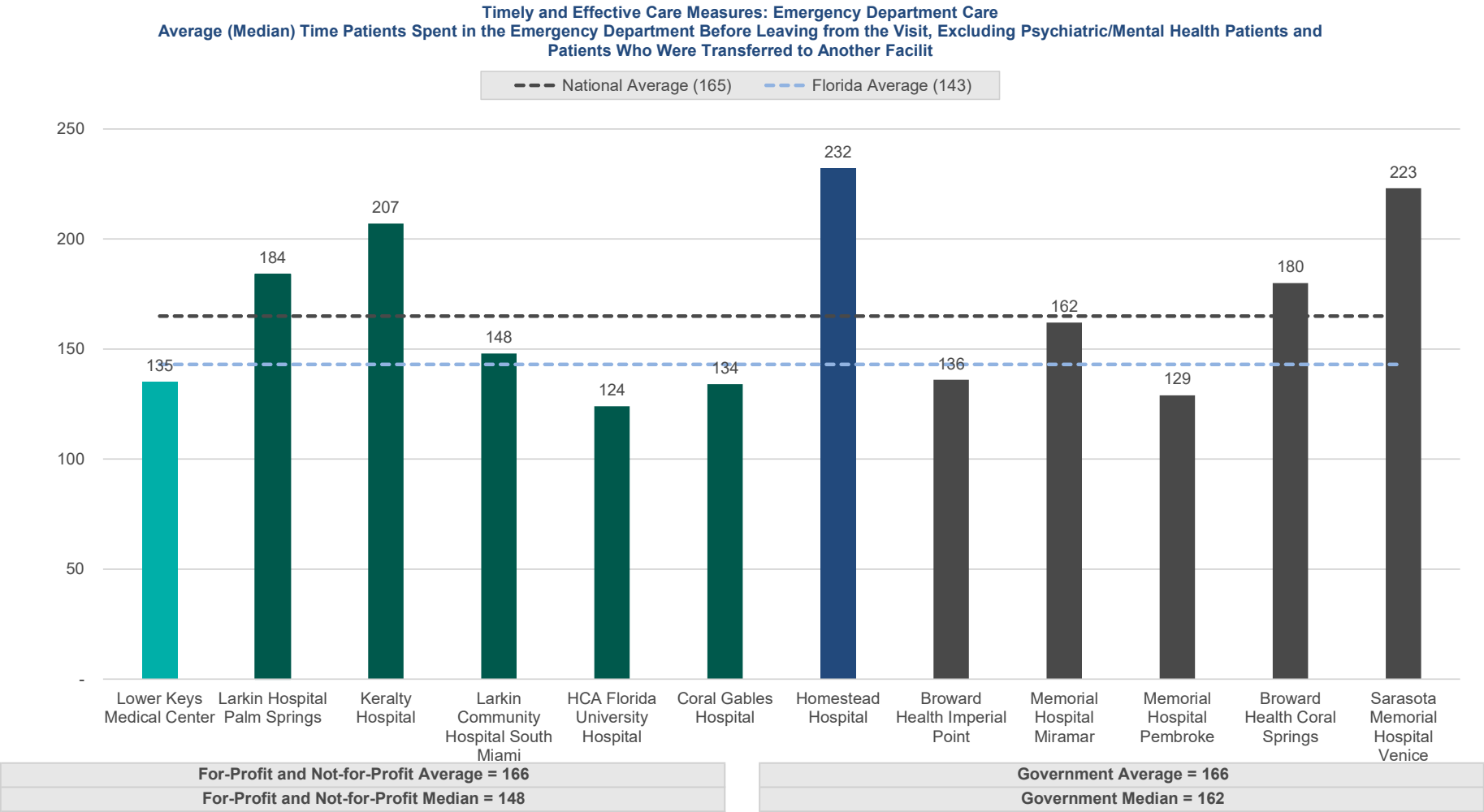




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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) This measure shows the average (median) time all patients spent in the emergency department before leaving from the visit, including psychiatric/mental health patients and patients who were transferred to another facility. It doesn't include patients who died in the emergency department, left without the approval of a licensed provider, or do not have where they went after they left the emergency department documented in their medical record. Long stays in the emergency department before a patient leaves may be a sign that the emergency department is understaffed or overcrowded. This may result in delays in treatment, increased suffering for those who wait, and unpleasant treatment environments. Lower numbers are better.



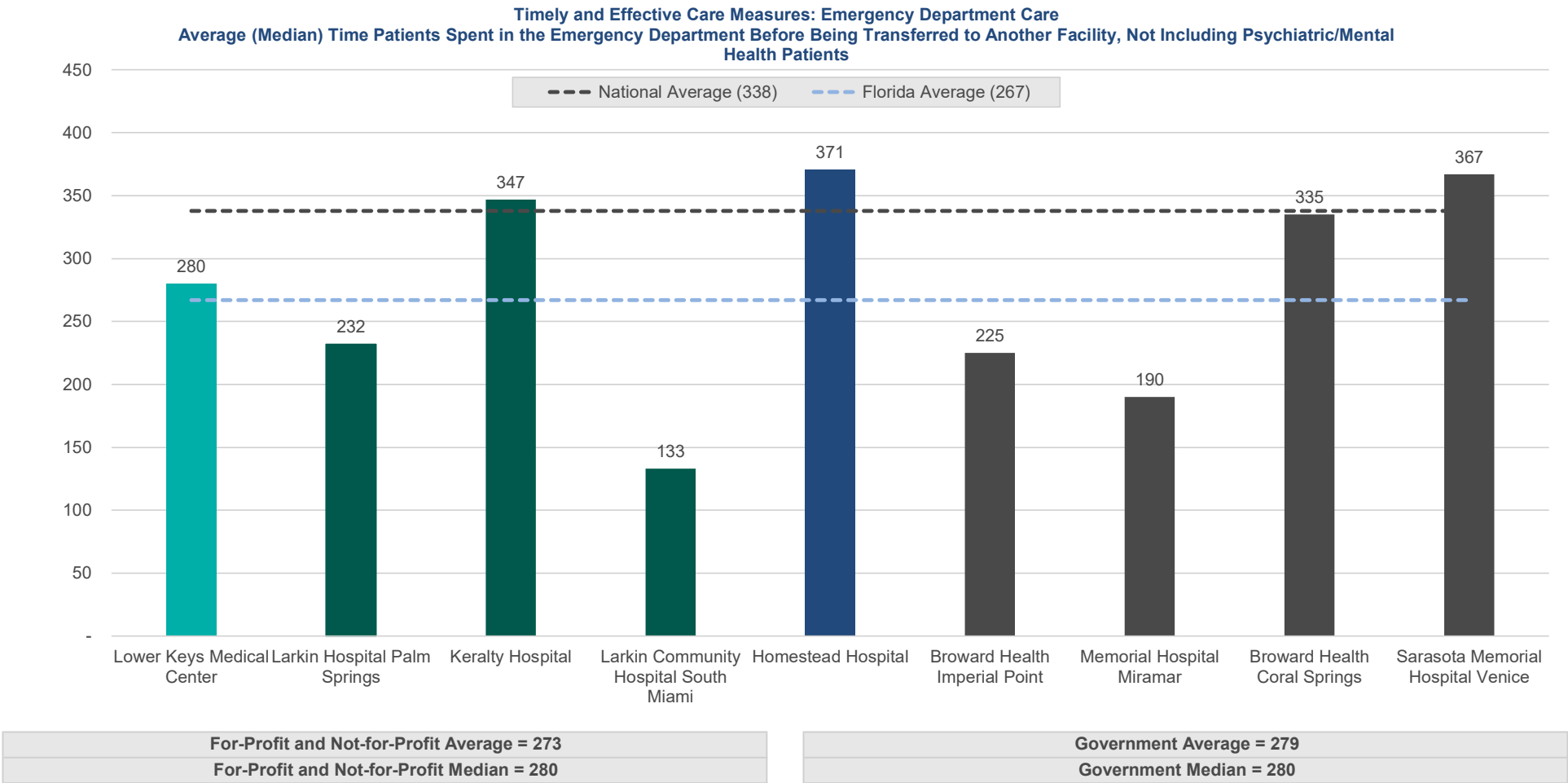


Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) This measure shows the average (median) time patients spent in the emergency department before leaving from the visit, excluding patients transferred to another facility or psychiatric care/mental health patients. It doesn't include patients who died in the emergency department, left without the approval of a licensed provider, or do not have where they went after they left the emergency department documented in their medical record. Lower numbers are better.



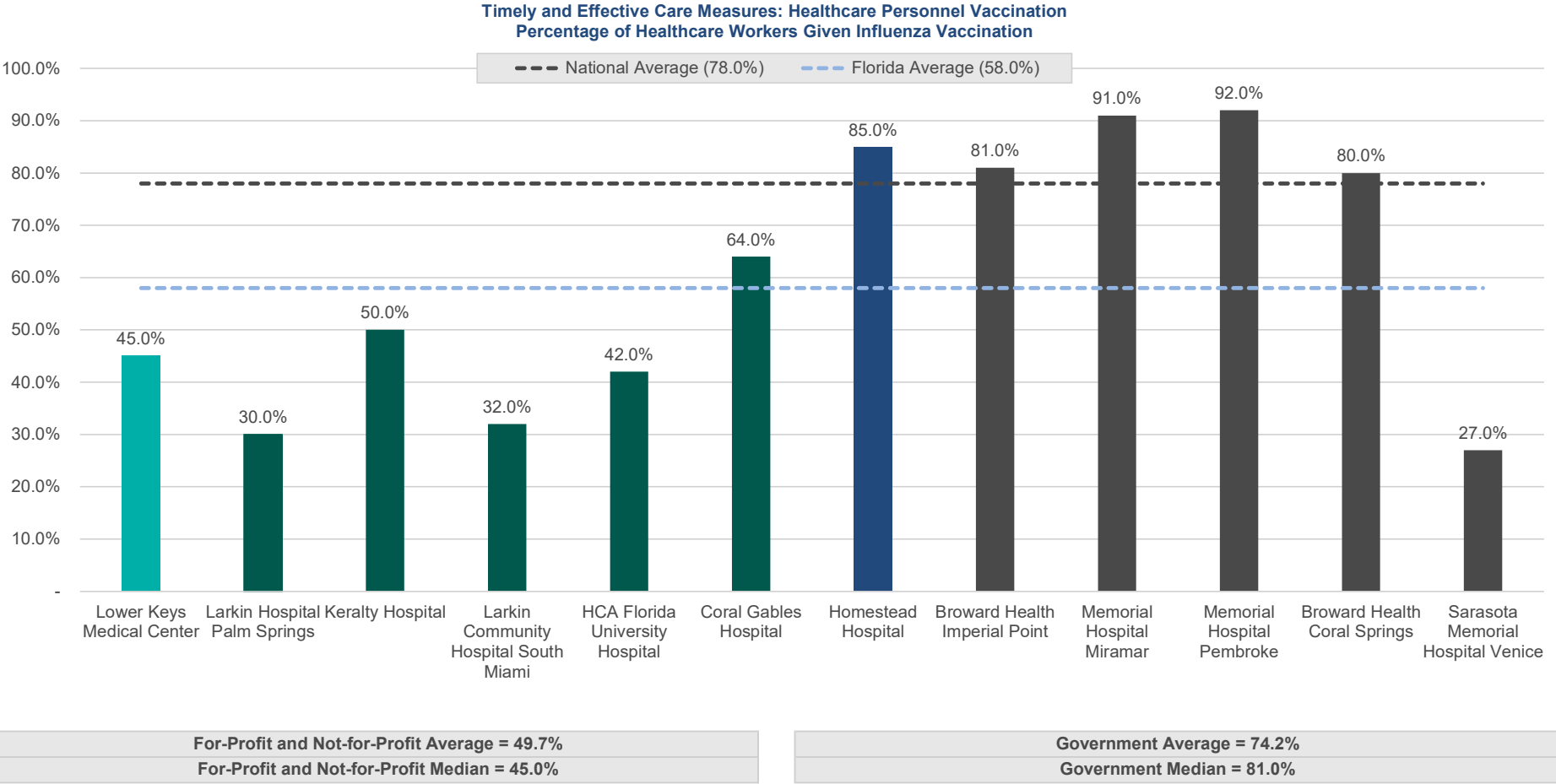


Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) This measure shows the average (median) time patients spent in the emergency department before leaving from the visit, for patients transferred to another facility. This measure doesn't include patients who died in the emergency department, left without the approval of a licensed provider, or do not have where they went after they left the emergency department documented in their medical record. Long stays in the emergency department before a patient leaves may be a sign that the emergency department is understaffed or overcrowded. This may result in delays in treatment, increased suffering for those who wait, and unpleasant treatment environments. Lower numbers are better.

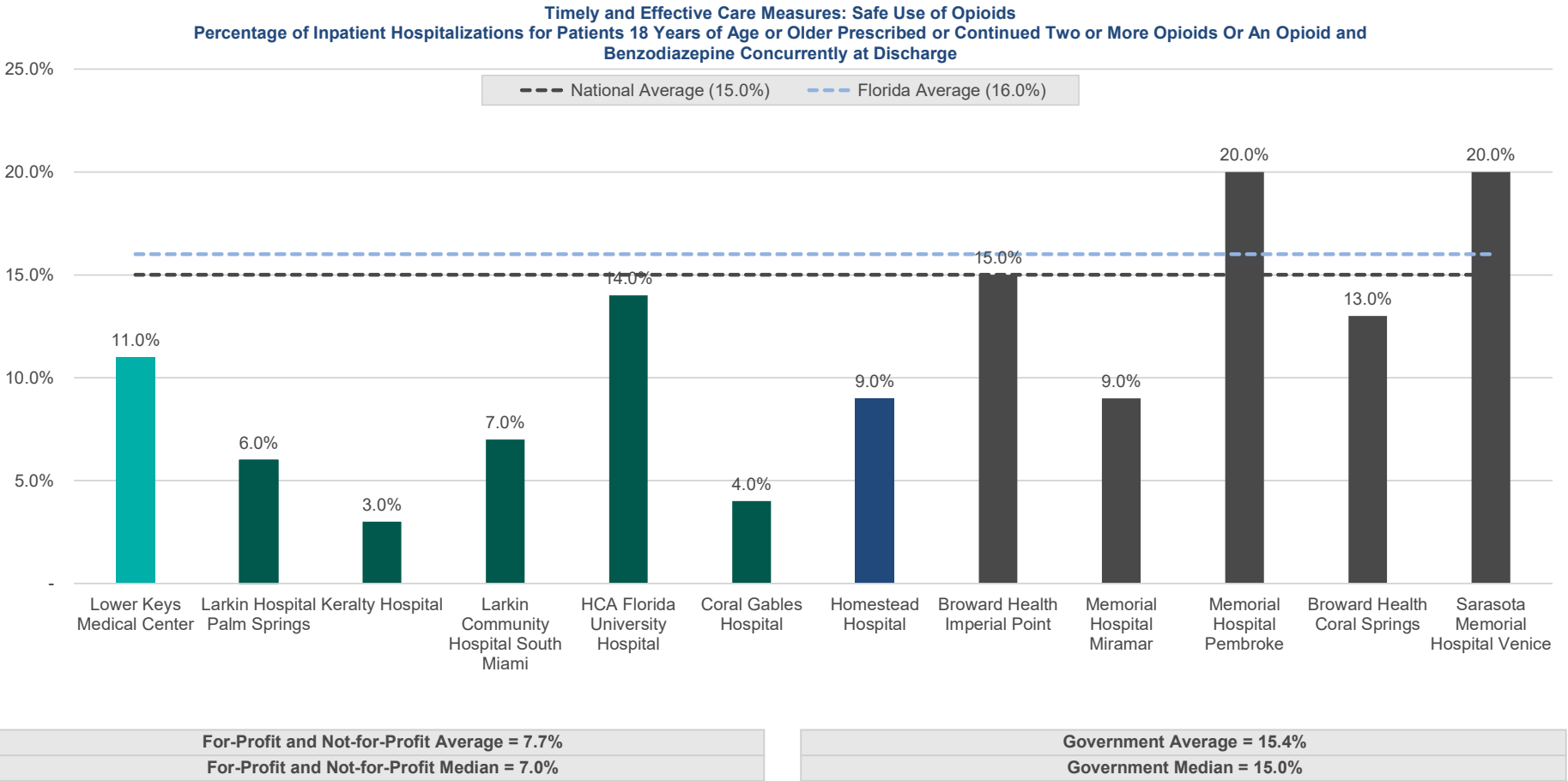




Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
(1) Source(s): https://www.medicare.gov/care-compare/			
(2) Source(s): https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care			
(3) Influenza, or the "flu," is a respiratory illness that is caused by flu viruses and easily spread from person to person. There are over 400,000 hospitalizations from the flu on average every year. An average of 45,000 Americans die annually due to the flu and its complications. Hospital staff and healthcare workers who are infected with the flu virus can transmit the virus to coworkers and patients, including those at higher risk for getting very sick from the flu. To reduce the spread of flu within a hospital, the Centers for Disease Control and Prevention recommends that all healthcare workers who work in a healthcare setting get the flu vaccine ("flu shot") each year. Vaccinating healthcare workers has been found to reduce the risk of flu illness, medical visits, antibiotic use, and flu-related deaths. It is recommended that all healthcare facilities provide the flu vaccine to their healthcare workers. This measure shows the percentage of all healthcare workers in a hospital that received the flu vaccine. Higher percentages are better.			





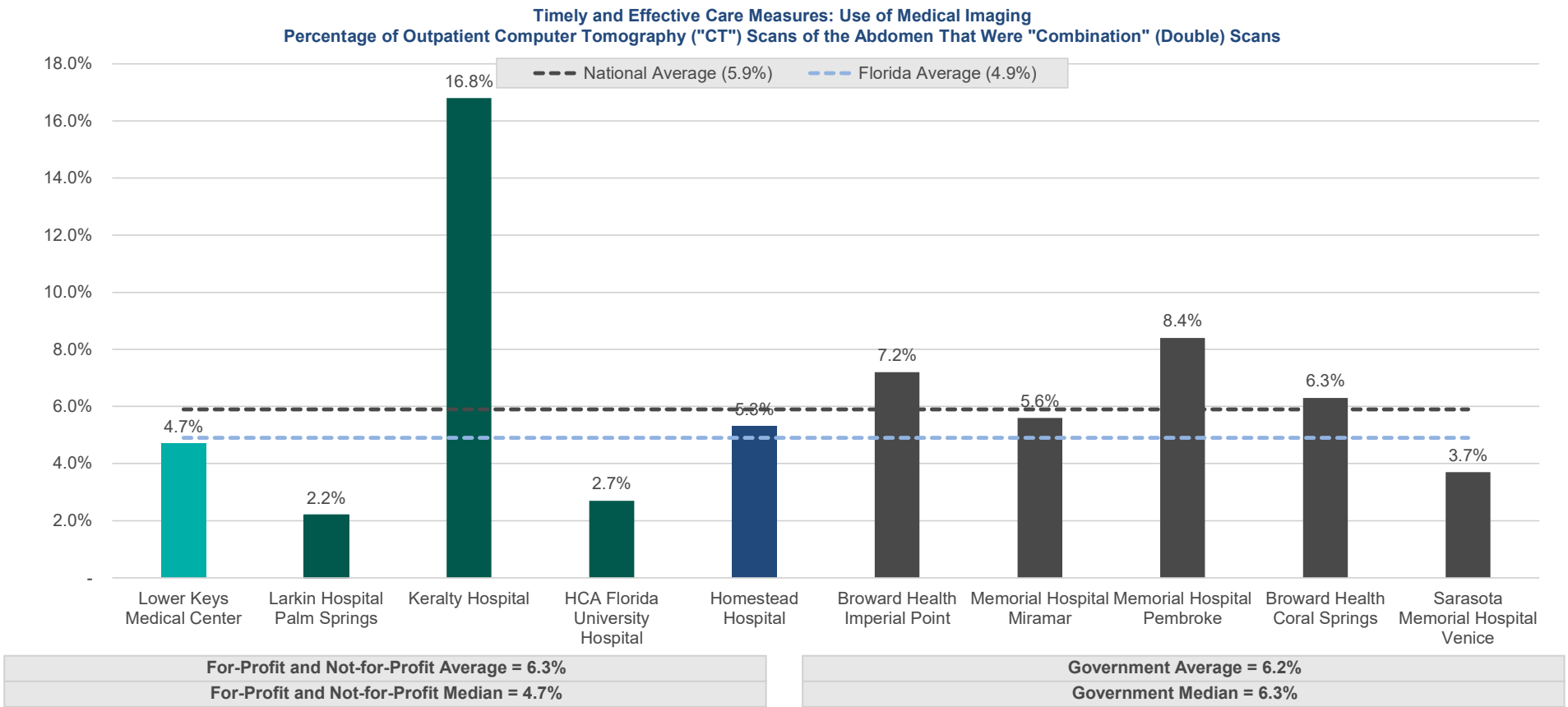
Notes and Sources

- Lower Keys Medical Center
- For-Profit Hospitals
- Not-for-Profit
- Government Not-for-Profit
- (1) Source(s): <https://www.medicare.gov/care-compare/>

(2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>

(3) Unintentional opioid overdose fatalities have become a major public health concern in the U.S. Reducing the number of unintentional overdoses has become a priority for numerous federal organizations including, but not limited to, the Centers for Disease Control and Prevention ("CDC"), the Federal Interagency Workgroup for Opioid Adverse Drug Events, and the Substance Abuse and Mental Health Services Administration ("SAMHSA"). Concurrent prescriptions of opioids or opioids and benzodiazepines places patients at an increased risk of respiratory depression. Adopting a measure that calculates the proportion of inpatient hospitalizations of patients discharged with 2 or more opioids or opioids and benzodiazepines concurrently has the potential to reduce preventable mortality and reduce the costs associated with adverse events related to opioid use by (1) encouraging providers to identify patients with concurrent prescriptions of opioids or opioids and benzodiazepines and (2) discouraging providers from prescribing two or more opioids or opioids and benzodiazepines concurrently. Lower percentages are better.



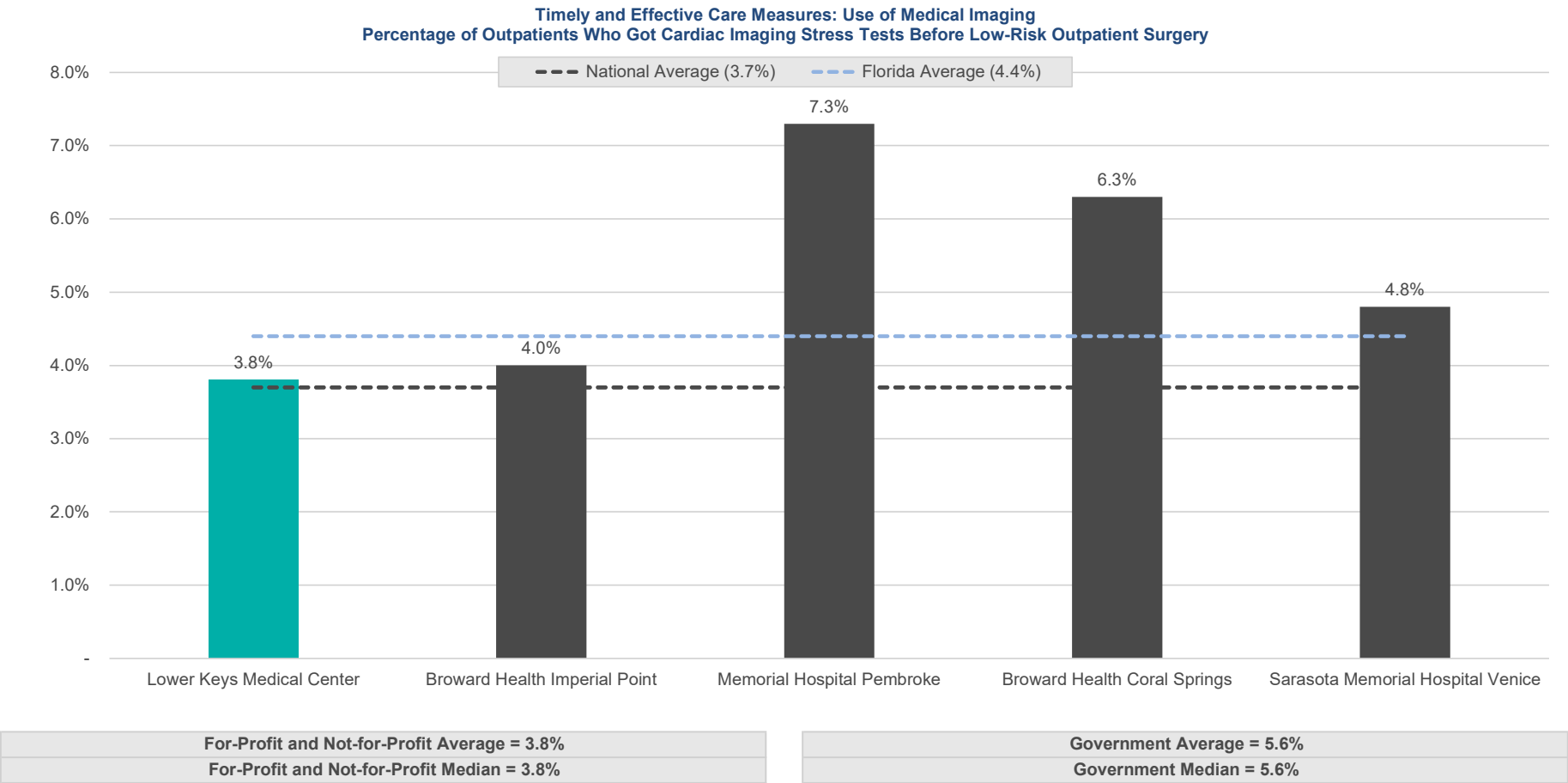


Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) A CT scan (also called a CAT scan) uses multiple X-rays to produce detailed pictures of the inside of the body (like bones, organs, and other body parts). For some, a substance called "contrast" is put into the patient's body before the scan begins, which helps make parts of the body stand out more clearly. Contrast can be either swallowed or injected into a vein. Risks of contrast include possible harm to the kidneys or allergic reactions. Contrast should not be used if it is not needed. A "combination" CT scan means that the patient gets two CT scans — one scan without contrast, followed by a second scan with contrast. Although combination CT scans are appropriate for some parts of the body and for some medical conditions, combination scans are not appropriate for the abdomen (or abdomen and pelvis) for most patients. Doing two scans when patients only need one needlessly doubles a patient's exposure to radiation. Radiation exposure from a single CT scan of the abdomen (or abdomen and pelvis) is about 11 times higher than for an ordinary X-ray of the abdomen. For a combination CT scan of the abdomen (or abdomen and pelvis), radiation exposure is 22 times higher than for an X-ray of the abdomen because the patient has two scans. When contrast is used, there are risks that can include possible harm to the kidneys or allergic reactions (especially if the contrast is injected). To avoid unnecessary risk, contrast should only be used when it is needed. The range for this measure is from 0% to 100%. For hospitals with higher percentages, it may indicate that the facility is routinely performing combination CT scans of the abdomen (or abdomen and pelvis) when a single scan is all they need. Lower percentages are better.



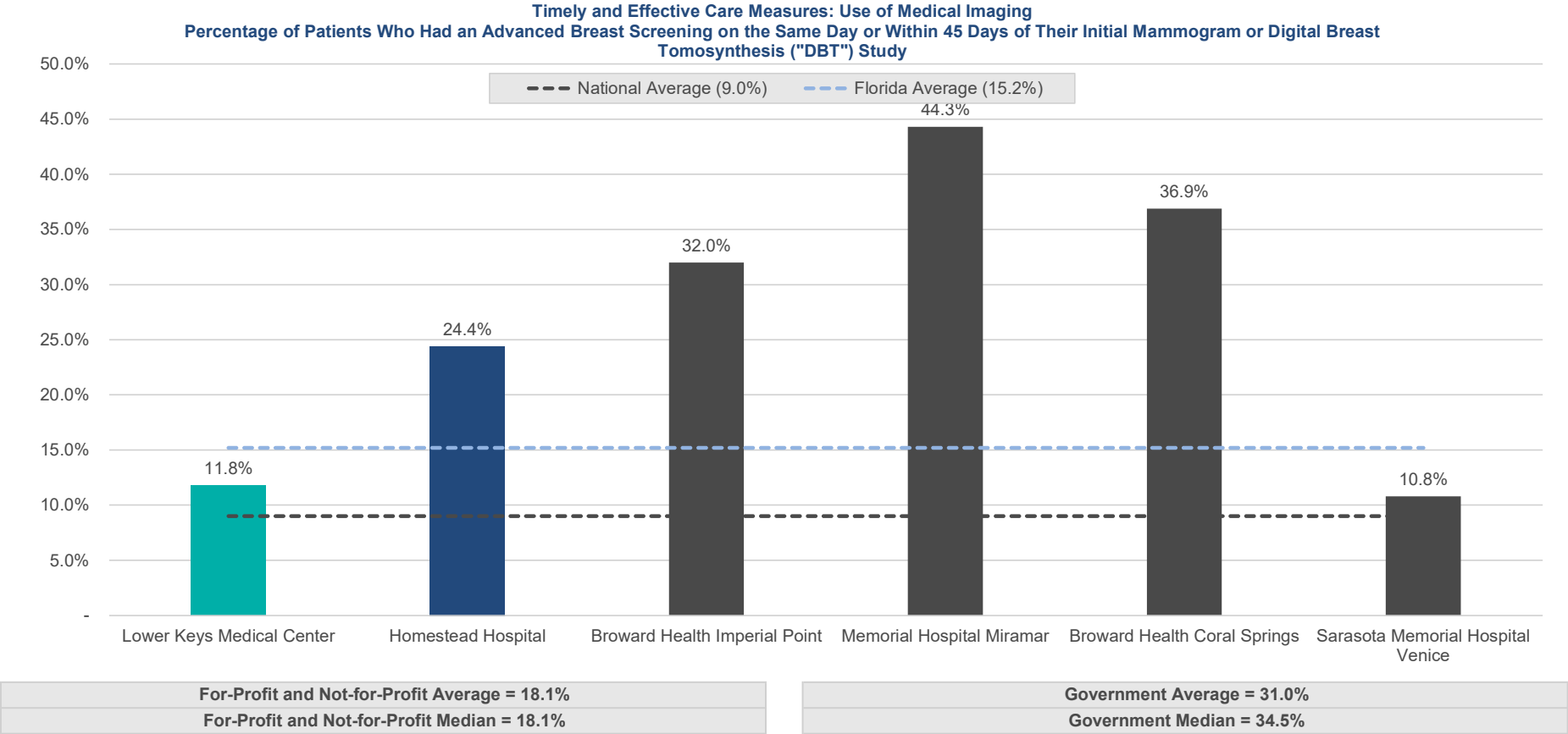


Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) A cardiac stress test measures the heart's ability to respond when it is working hard and can be useful in evaluating a patient's surgical risk. Experts agree, however, that these tests are not necessary before most low-risk outpatient surgical procedures, like colonoscopies, cataract surgery, biopsies, or endoscopies (using an instrument to look inside the body), because these procedures put very little stress on the heart. Patients with certain risk factors that increase the likelihood of having complications during or after these procedures are not included in the measure. This measure shows the percentage of all cardiac stress tests done in a hospital outpatient imaging department using echocardiograms, CT scans, cardiac computed tomography angiography ("CCTA") studies, and MRIs for Medicare patients who were going to have certain low-risk outpatient surgical procedures. Hospital outpatient imaging departments that have higher percentages on this measure may be doing more imaging tests than they need to. Lower percentages are better.



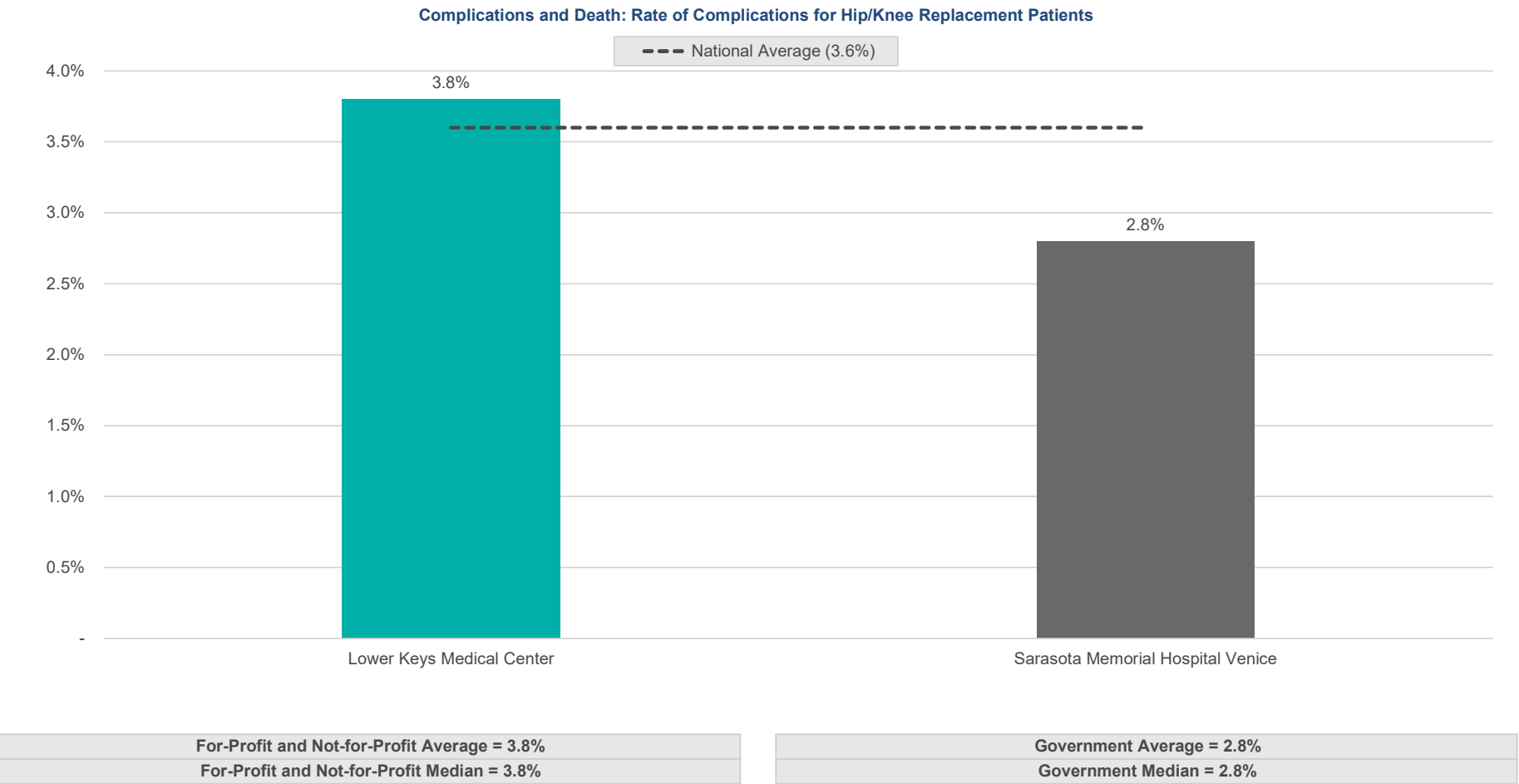


Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/timely-effective-care>
- (3) Performing breast imaging in the outpatient setting facilitates early detection of malignancies. However, there are potentially negative consequences if mammography and DBT recall rates are either too high or too low. Performing diagnostic mammography or DBT, as result of a false-positive screening study or other errant data, has the potential to expose patients to unnecessary follow up. This could result in increased prevalence of radiation-induced cancers in younger patients, including those carrying related gene mutations, such as BRCA-1 and BRCA-2, or additional imaging and biopsies, which could lead to unnecessary procedures for individuals who do not have breast cancer. In contrast, recalling too few patients for follow-up imaging may lead to delayed diagnoses, higher stages at diagnosis, and/or undetected cases of breast cancer. Given the potential negative consequences associated with too many or too few diagnostic mammography and DBT studies performed within the population, evidence from the clinical literature suggests appropriate recall rates should fall between 5.0% and 12.0%. Hospitals that are rated well on this measure will have a recall rate that falls between 5.0% and 12.0%. If a percentage is lower than 5.0%, it may mean the facility is missing cases of cancer. If a percentage is higher than 12.0%, it may mean the facility is recalling too many beneficiaries for follow-up imaging.



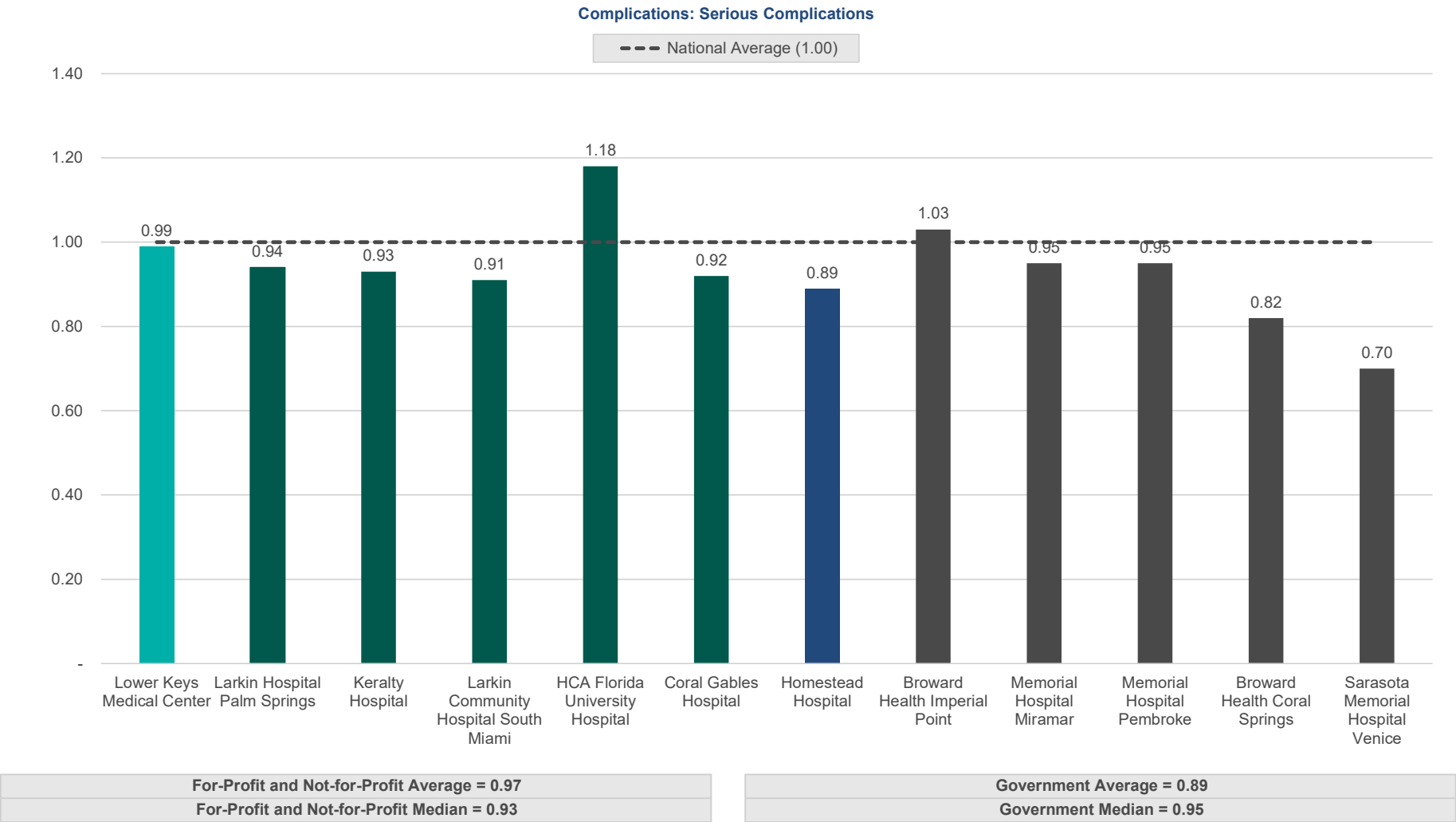


Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) <https://data.cms.gov/provider-data/topics/hospitals/complications-deaths>
- (3) During or after hip/knee replacement surgery there is a chance that a patient may experience a problem or complication, or may even die. Complications included in this measure are: infection, heart attack, pneumonia, wounds that split open or bleed after surgery, serious blood clots, replacement hip/knee joints that don't work, and death. Higher rates of these serious, but potentially preventable, complications may be a sign of poorer quality hospital care. Hospitals can reduce the likelihood of these serious complications by following clinical guidelines for patient safety, maintaining effective communication channels between providers, and better coordinating patients' transition to the outpatient setting. You can see if the hospital's performance on this complication measure is lower (better) than the national rate, no different than the national rate, or higher (worse) than the national rate. For some hospitals, the number of cases is too small to reliably tell how well the hospital is performing, so no comparison to the national rate is shown. Lower numbers are better



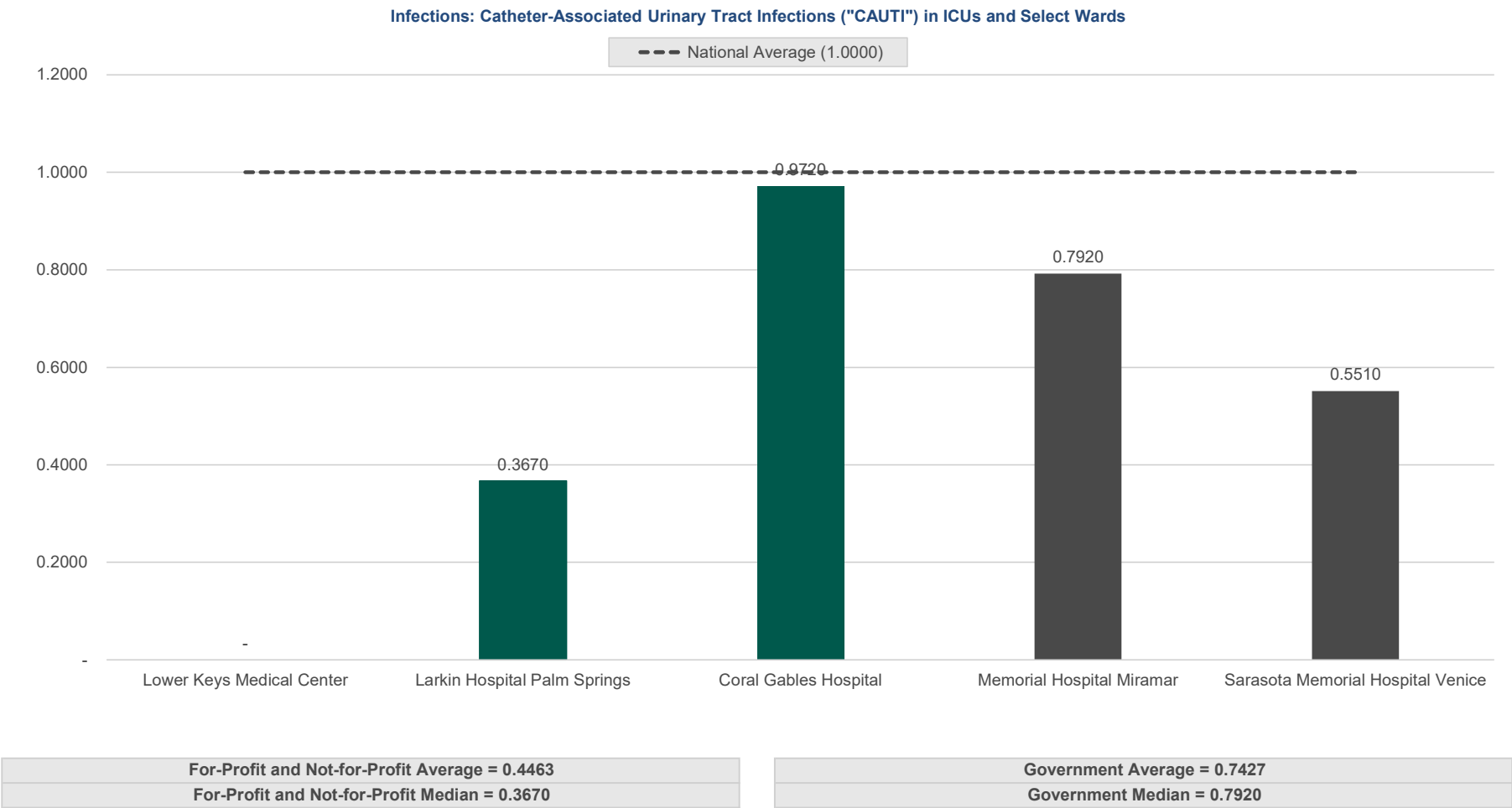


Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) <https://data.cms.gov/provider-data/topics/hospitals/complications-deaths>
- (3) Higher rates of these serious, but potentially preventable, complications may be a sign of poorer quality hospital care. Hospitals can reduce the chance of these serious complications by following safe practices. Lower numbers are better.



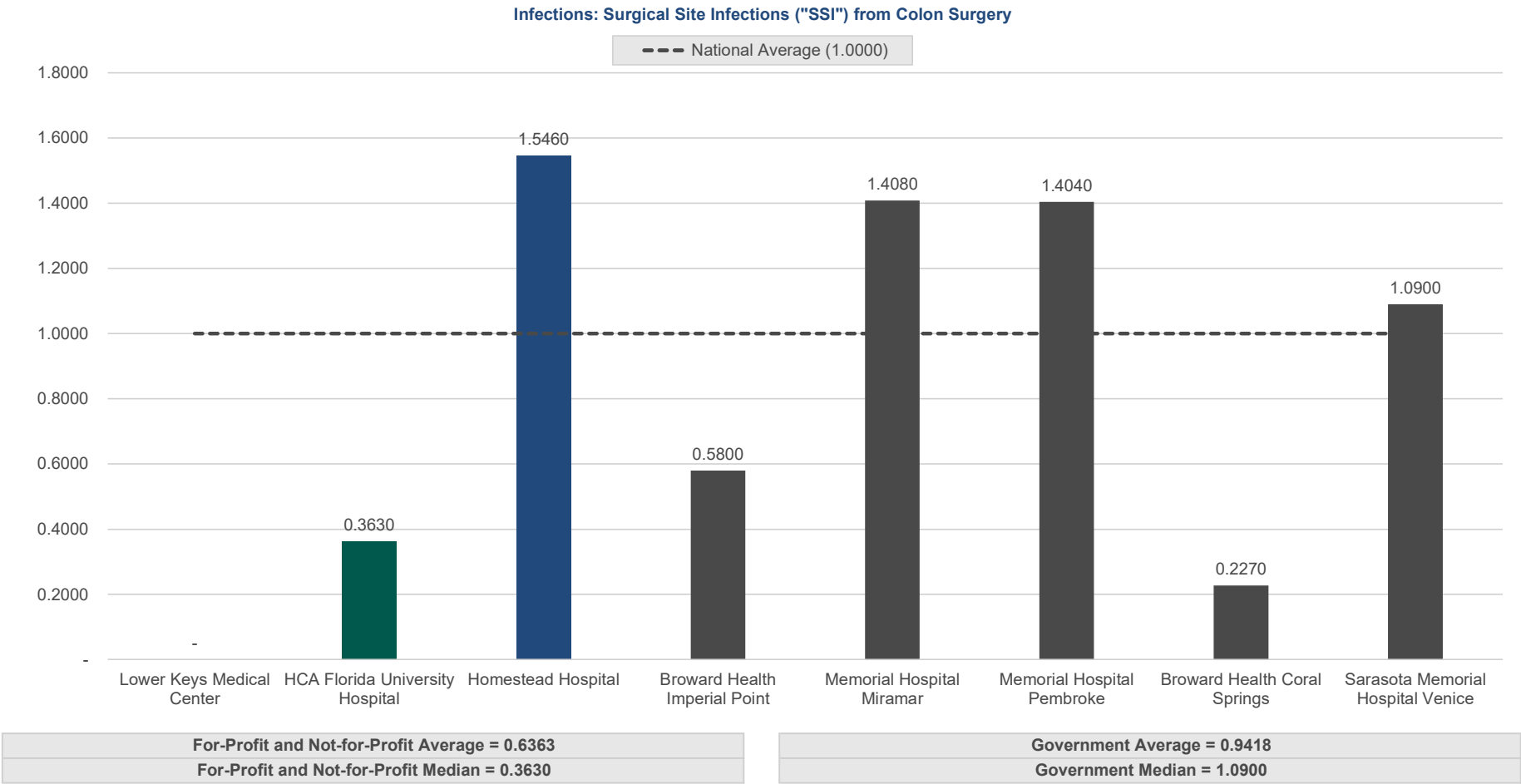


Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) <https://data.cms.gov/provider-data/topics/hospitals/complications-deaths>
- (3) CAUTI data are available that include ICUs and adult and pediatric medical, surgical, and medical/surgical wards. A catheter is a drainage tube inserted into a patient's bladder through the urethra and left in place to collect urine. When not put in correctly, kept clean, or when left in place for long periods of time, catheters can become an easy way for germs to enter the body and cause serious infections in the urinary tract. These infections are called CAUTIs. They may be preventable when healthcare providers use infection control steps recommended by the CDC. This measure compares the number of CAUTIs in certain locations in a hospital to a national benchmark. Lower numbers are better. A score of zero (0)—meaning no CAUTIs—is best



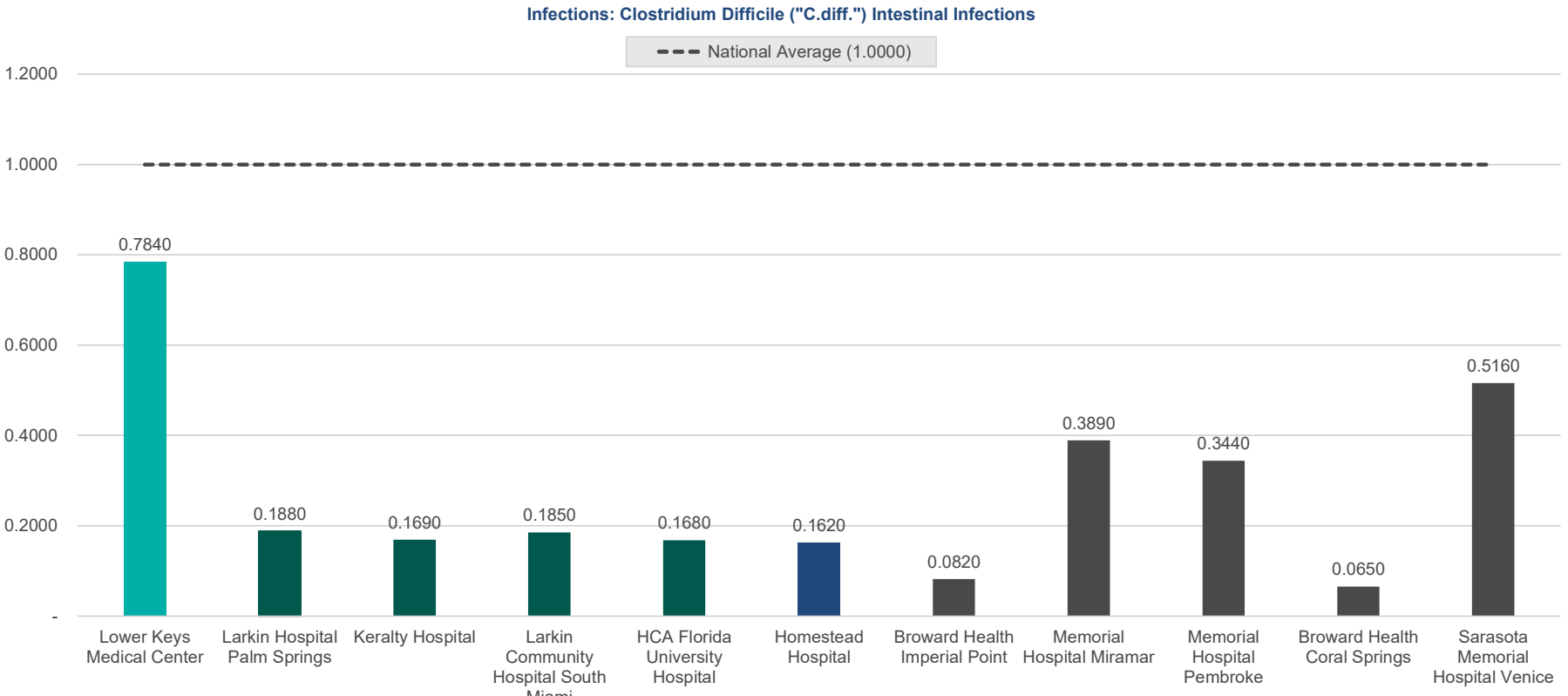


Notes and Sources

Table with 4 columns: Lower Keys Medical Center, For-Profit Hospitals, Not-for-Profit, Government Not-for-Profit

- (1) Source(s): https://www.medicare.gov/care-compare/
(2) https://data.cms.gov/provider-data/topics/hospitals/complications-deaths
(3) A surgical operative procedure is one that is performed on a patient in an operating room where a surgeon makes at least one incision through the skin or mucous membrane to give important medical treatment. When not conducted in a sterile environment and following sterile procedures, a surgical site can become an easy way for germs to enter the body and cause serious infections in a patient, which can affect the skin, tissues under the skin, organs, or implanted material. These infections are called SSIs, and they can be deadly. SSIs are mostly preventable when healthcare providers use infection control steps recommended by the CDC. The SSI measure compares the number of surgical site infections from specific types of operative procedures conducted at a hospital to a national benchmark. Lower numbers are better. A score of zero (0)—meaning no SSIs—is best.





For-Profit and Not-for-Profit Average = 0.2760
For-Profit and Not-for-Profit Median = 0.1770

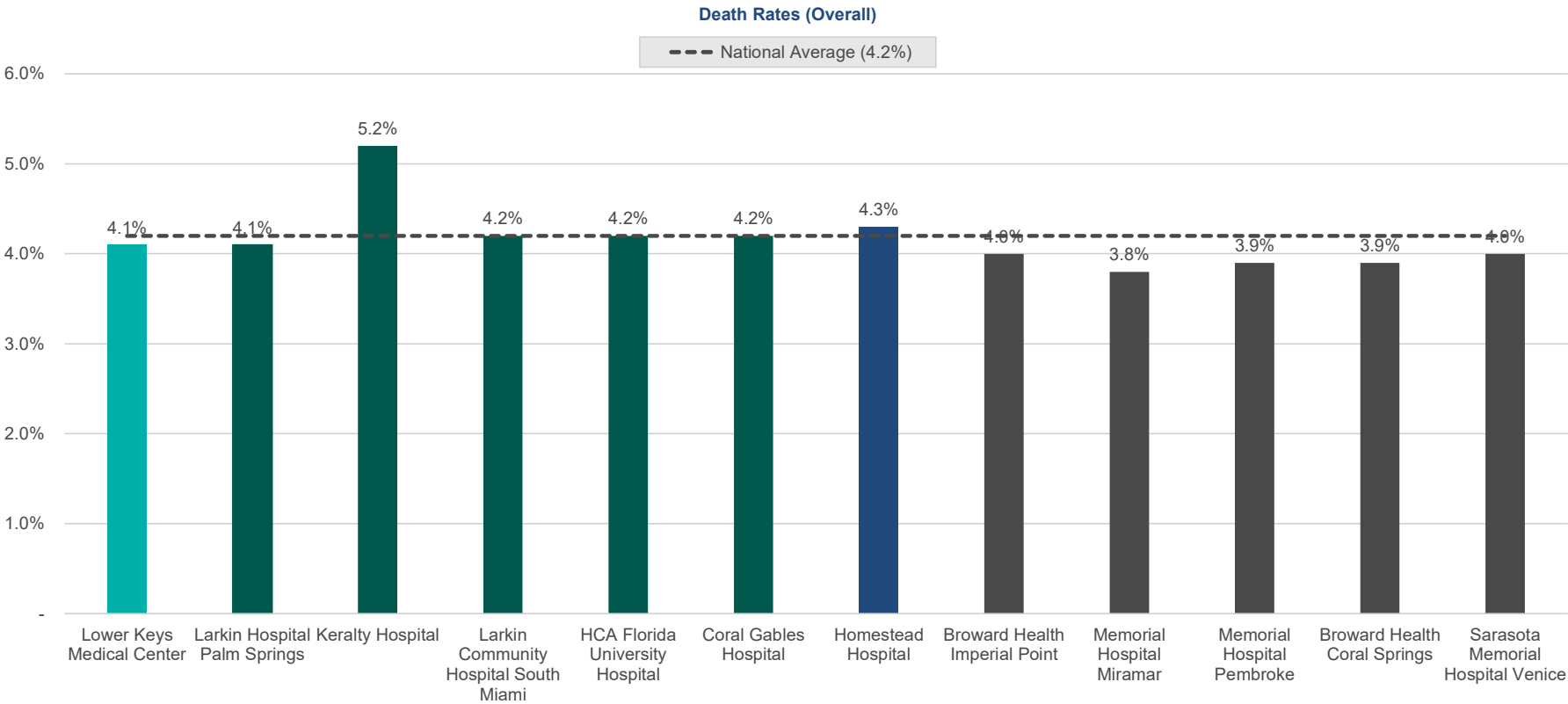
Government Average = 0.2792
Government Median = 0.3440

Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) <https://data.cms.gov/provider-data/topics/hospitals/complications-deaths>
- (3) C. diff is a type of bacteria that causes inflammation of the colon. C. diff infections can cause severe diarrhea, fever, appetite loss, nausea, and abdominal pain. Hospital staff can prevent C. diff from being transmitted to patients by taking certain precautions, like washing hands; using protective gloves and gowns; practicing responsible use of antibiotics; covering the mouth, nose, and eyes when appropriate; and sterilizing equipment between patients. Responsible use of antibiotics includes limiting the amount and length of treatment to only what is needed to successfully combat the infection and avoiding the use of more powerful antibiotics when a narrow-spectrum antibiotic will work. Symptoms from C. diff infections often take a few days to develop. Patients are tested for C. diff infections if they show signs of illness while in the hospital. This measure compares the number of stool samples that tested positive for C. diff toxin four or more days after the patient entered the hospital to a national benchmark.





For-Profit and Not-for-Profit Average = 4.3%
For-Profit and Not-for-Profit Median = 4.2%

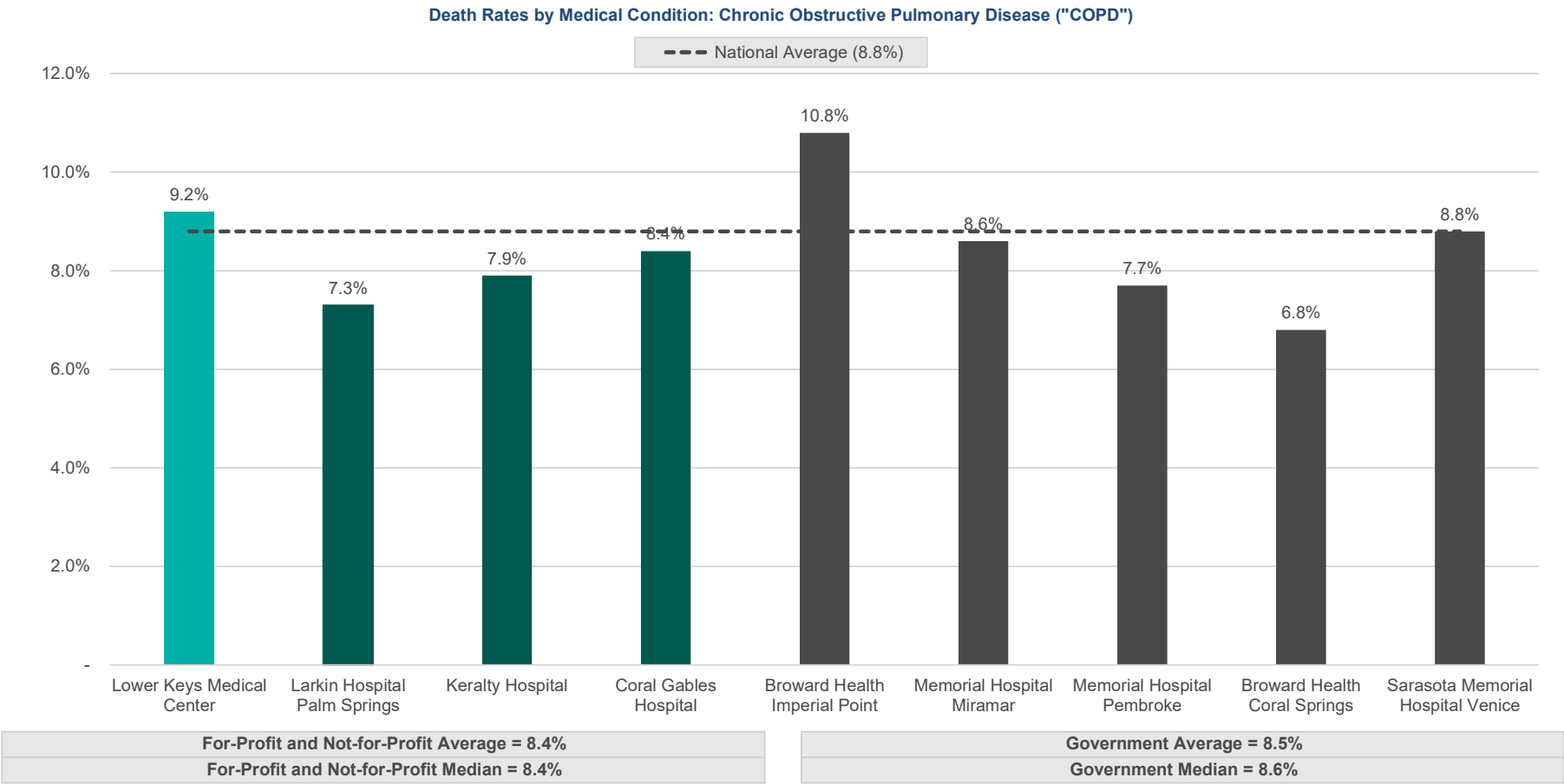
Government Average = 3.9%
Government Median = 3.9%

Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) <https://data.cms.gov/provider-data/topics/hospitals/complications-deaths>
- (3) The death rates show whether patients died within 30 days of surgery or being hospitalized for a specific condition. Death rates provide information about important aspects of hospital care that affect patients' outcomes – like prevention of and response to complications, emphasis on patient safety, and the timeliness of care. Death rates are measured within 30 days because deaths after a longer time period may have less to do with the care the hospital provided and more to do so with other complicating illnesses, patients' own behavior, or other case services received after they leave the hospital. The death rates include hospitalizations for Medicare beneficiaries 65 or older who were enrolled in Original Medicare for 12 months before their hospital admission. The death rates do not include patients who left the hospital against medical advice. Medicare calculates hospital-specific death rates for each hospital using Medicare claims data and eligibility data. To accurately compare hospital performance, the death measures adjust for patient characteristics that may make death more likely. These characteristics include the patient's age, past medical history, and other diseases or conditions (comorbidities) the patient had when they were admitted that are known to increase the patient's chance of death.



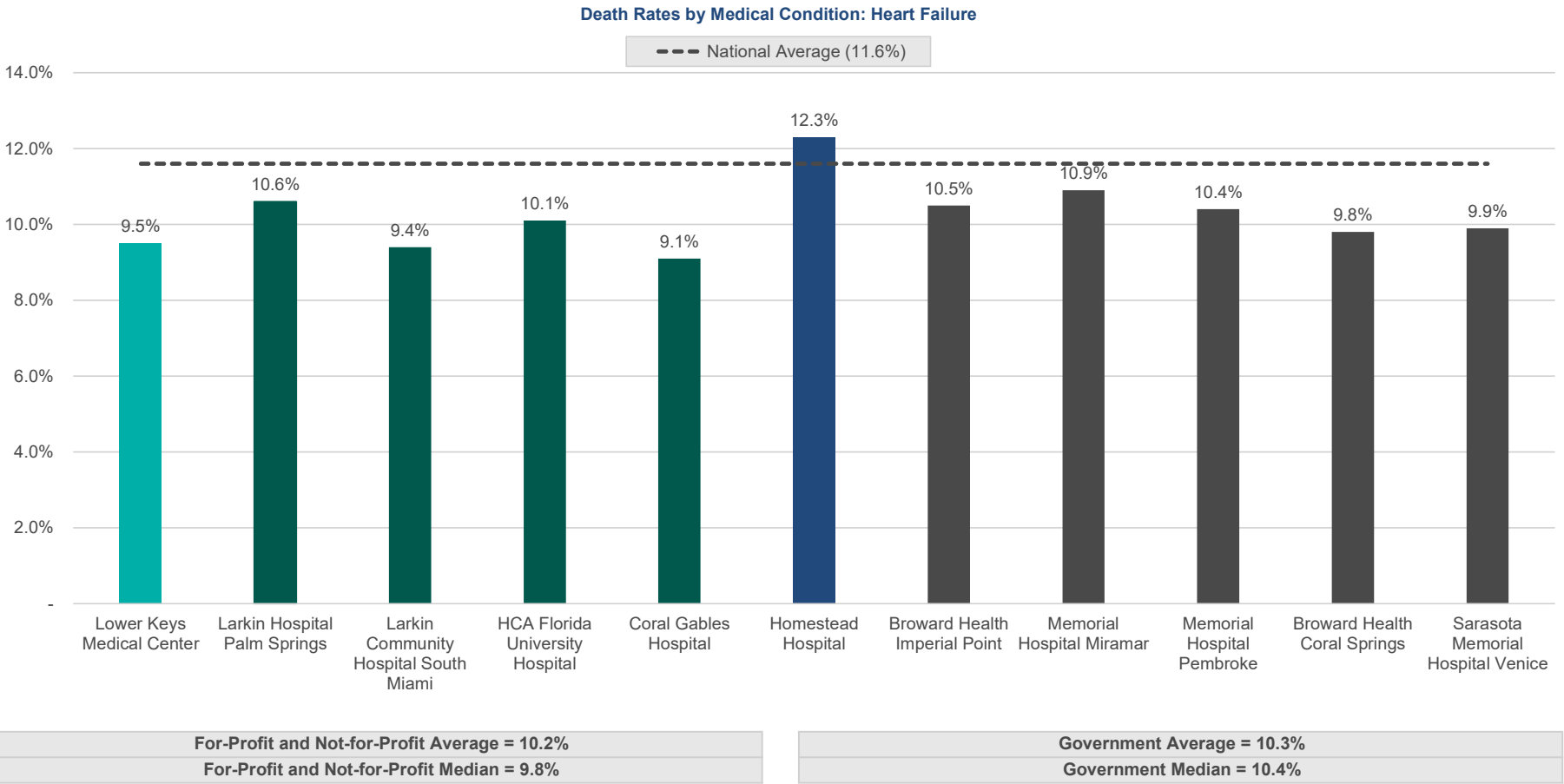


Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) <https://data.cms.gov/provider-data/topics/hospitals/complications-deaths>
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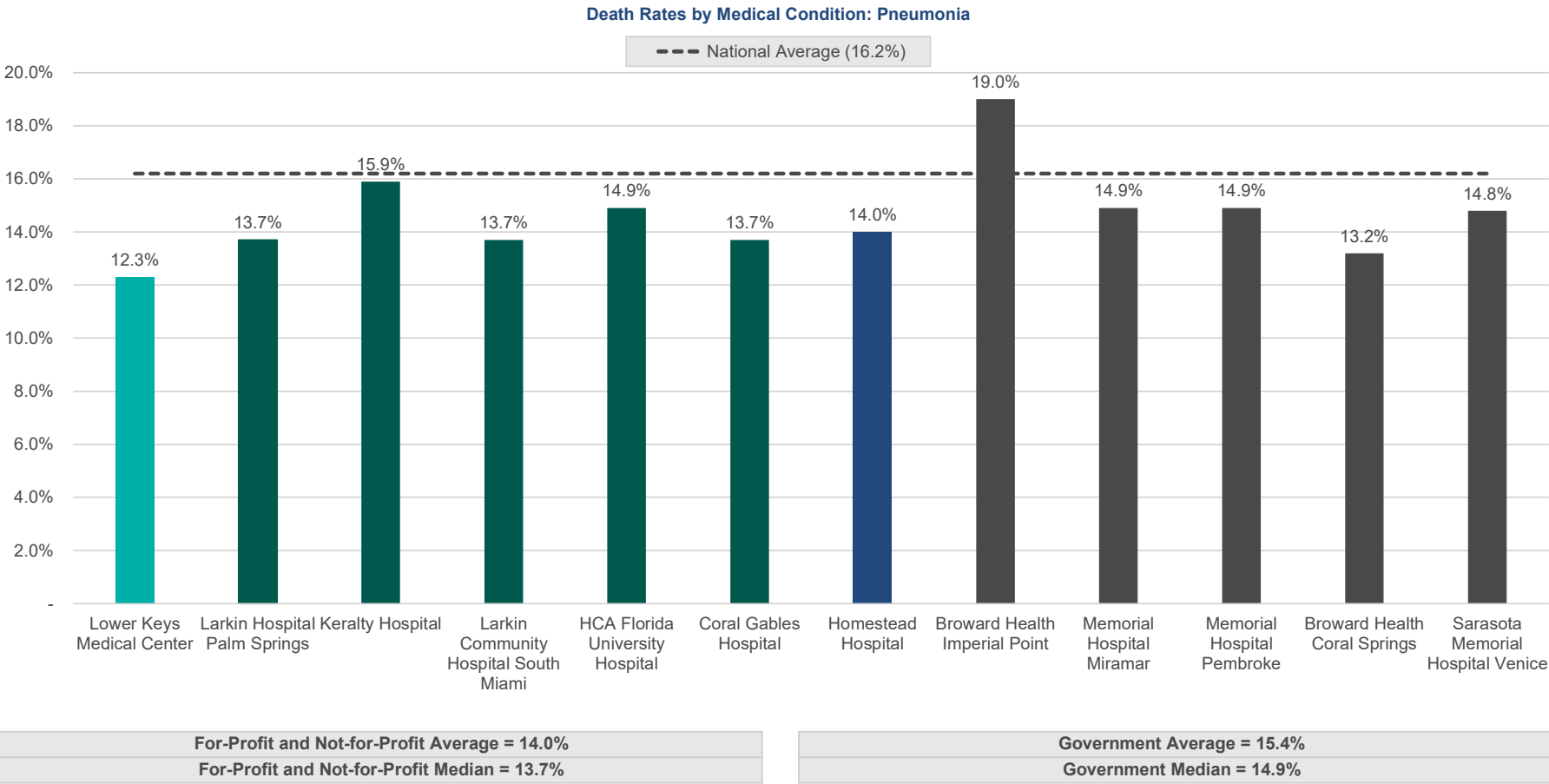


Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) <https://data.cms.gov/provider-data/topics/hospitals/complications-deaths>
- (3) The death rates show whether patients died within 30 days of surgery or being hospitalized for a specific condition. Death rates provide information about important aspects of hospital care that affect patients' outcomes – like prevention of and response to complications, emphasis on patient safety, and the timeliness of care. Death rates are measured within 30 days because deaths after a longer time period may have less to do with the care the hospital provided and more to do so with other complicating illnesses, patients' own behavior, or other case services received after they leave the hospital. The death rates include hospitalizations for Medicare beneficiaries 65 or older who were enrolled in Original Medicare for 12 months before their hospital admission. The death rates do not include patients who left the hospital against medical advice. Medicare calculates hospital-specific death rates for each hospital using Medicare claims data and eligibility data. To accurately compare hospital performance, the death measures adjust for patient characteristics that may make death more likely. These characteristics include the patient's age, past medical history, and other diseases or conditions (comorbidities) the patient had when they were admitted that are known to increase the patient's chance of death.

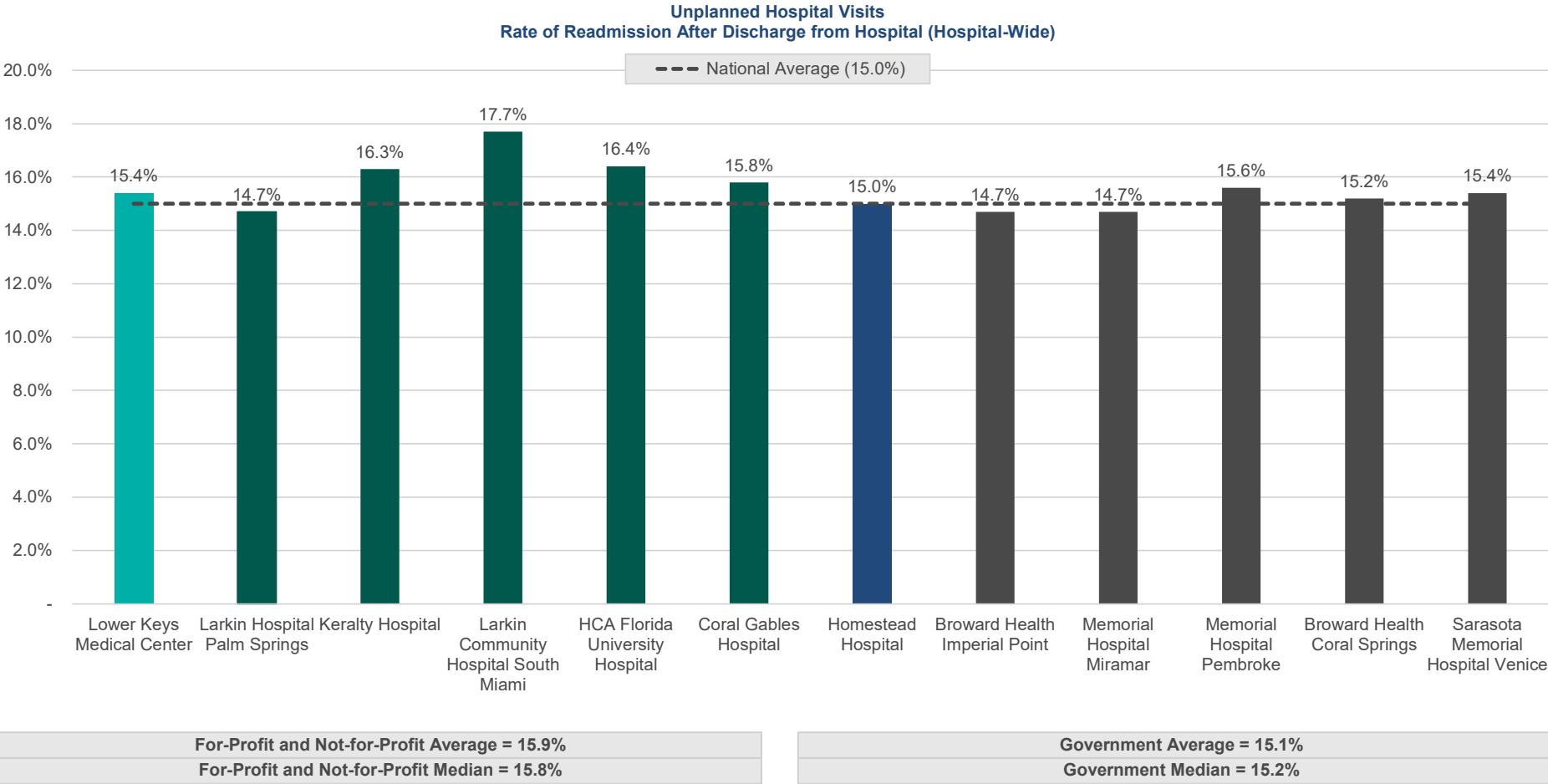




Notes and Sources

- Lower Keys Medical Center
- For-Profit Hospitals
- Not-for-Profit
- Government Not-for-Profit
- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) <https://data.cms.gov/provider-data/topics/hospitals/complications-deaths>
- (3) The death rates show whether patients died within 30 days of surgery or being hospitalized for a specific condition. Death rates provide information about important aspects of hospital care that affect patients' outcomes – like prevention of and response to complications, emphasis on patient safety, and the timeliness of care. Death rates are measured within 30 days because deaths after a longer time period may have less to do with the care the hospital provided and more to do so with other complicating illnesses, patients' own behavior, or other case services received after they leave the hospital. The death rates include hospitalizations for Medicare beneficiaries 65 or older who were enrolled in Original Medicare for 12 months before their hospital admission. The death rates do not include patients who left the hospital against medical advice. Medicare calculates hospital-specific death rates for each hospital using Medicare claims data and eligibility data. To accurately compare hospital performance, the death measures adjust for patient characteristics that may make death more likely. These characteristics include the patient's age, past medical history, and other diseases or conditions (comorbidities) the patient had when they were admitted that are known to increase the patient's chance of death.





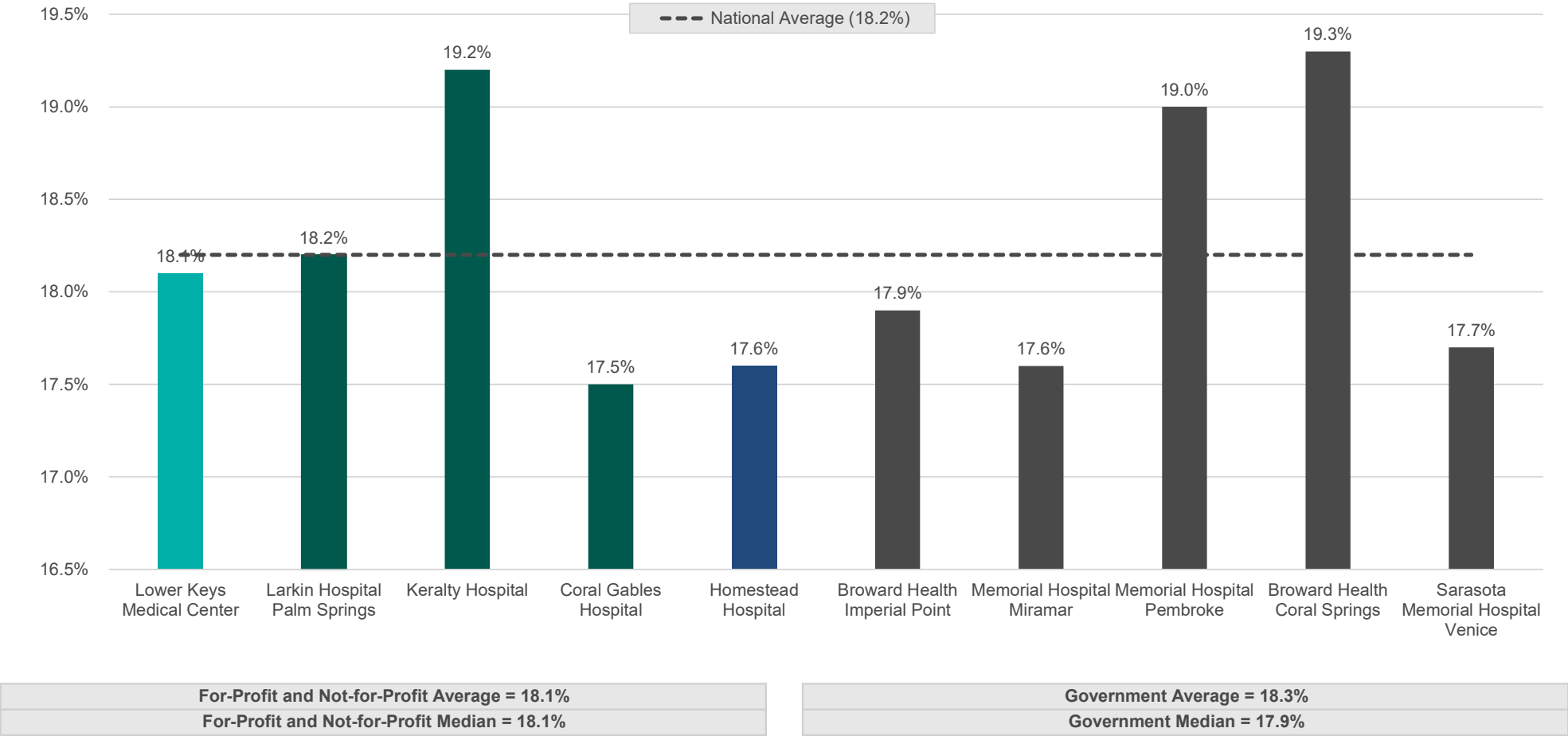
Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/unplanned-hospital-visits>
- (3) The overall rate of unplanned readmission after discharge from the hospital (also called "hospital-wide readmission") focuses on whether patients who were discharged from a hospital stay were hospitalized again within 30 days. All medical, surgical, gynecological, neurological, cardiovascular, and cardiorespiratory hospital patients are included in this measure. Patients may have returned to the same hospital or to a different hospital. They may have been readmitted for a condition that is related to their recent hospital stay, or for an entirely different reason. The overall rate of unplanned readmission can show whether a hospital is doing its best to prevent complications, providing clear discharge instructions to patients, and helping to ensure patients make a smooth transition to their home or another setting like a nursing home.



Unplanned Hospital Visits by Medical Condition
Rate of Readmission for Chronic Obstructive Pulmonary Disease ("COPD") Patients

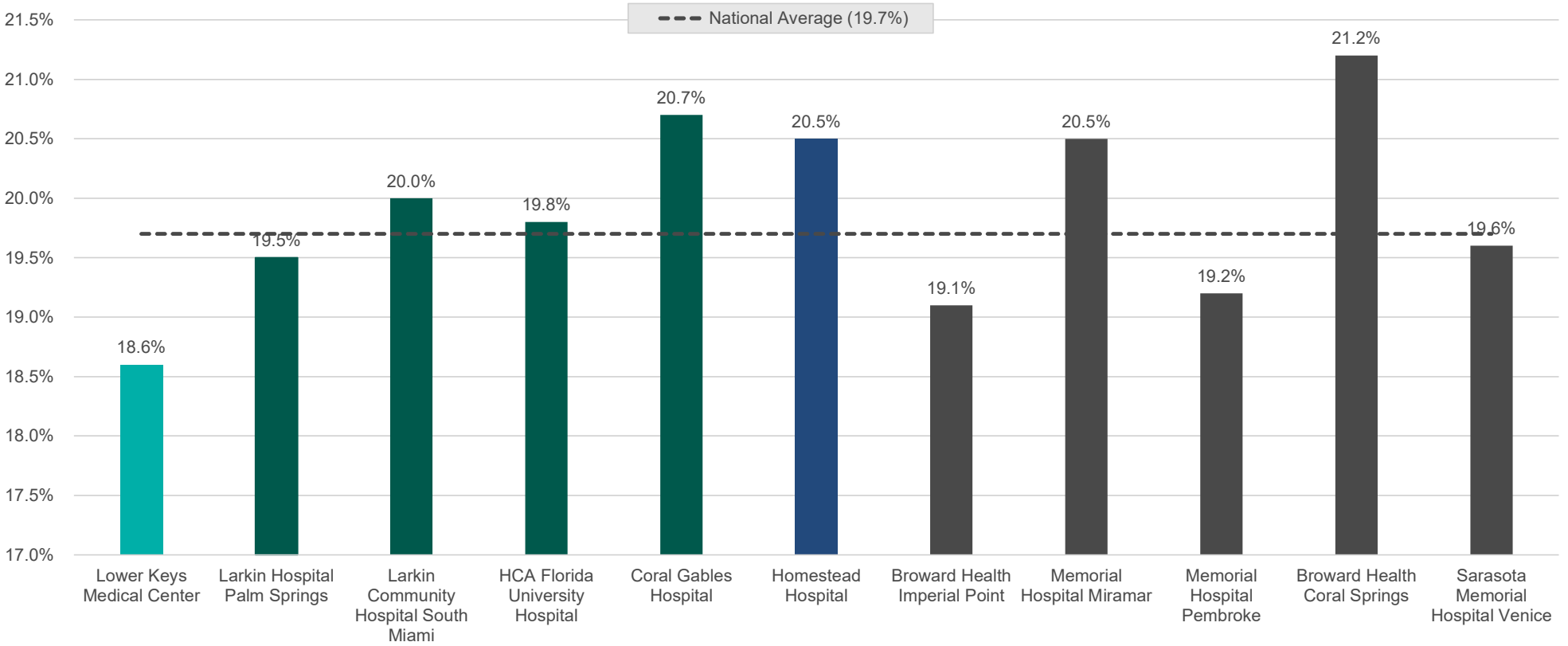


Notes and Sources

- Lower Keys Medical Center
- For-Profit Hospitals
- Not-for-Profit
- Government Not-for-Profit
- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/unplanned-hospital-visits>
- (3) The rates of unplanned readmission focus on whether patients who were discharged from a hospital were hospitalized again within 30 days. Patients may return to the same hospital or to a different hospital. Their readmission might be for a condition that is related to their recent hospitalization, or for a different reason. Rates of unplanned readmission can show whether a hospital is doing its best to prevent complications, provide clear discharge instructions to patients, and help patients make a smooth transition to their home or another setting like a nursing home.



Unplanned Hospital Visits by Medical Condition
Rate of Readmission for Heart Failure Patients



For-Profit and Not-for-Profit Average = 19.9%
For-Profit and Not-for-Profit Median = 19.9%

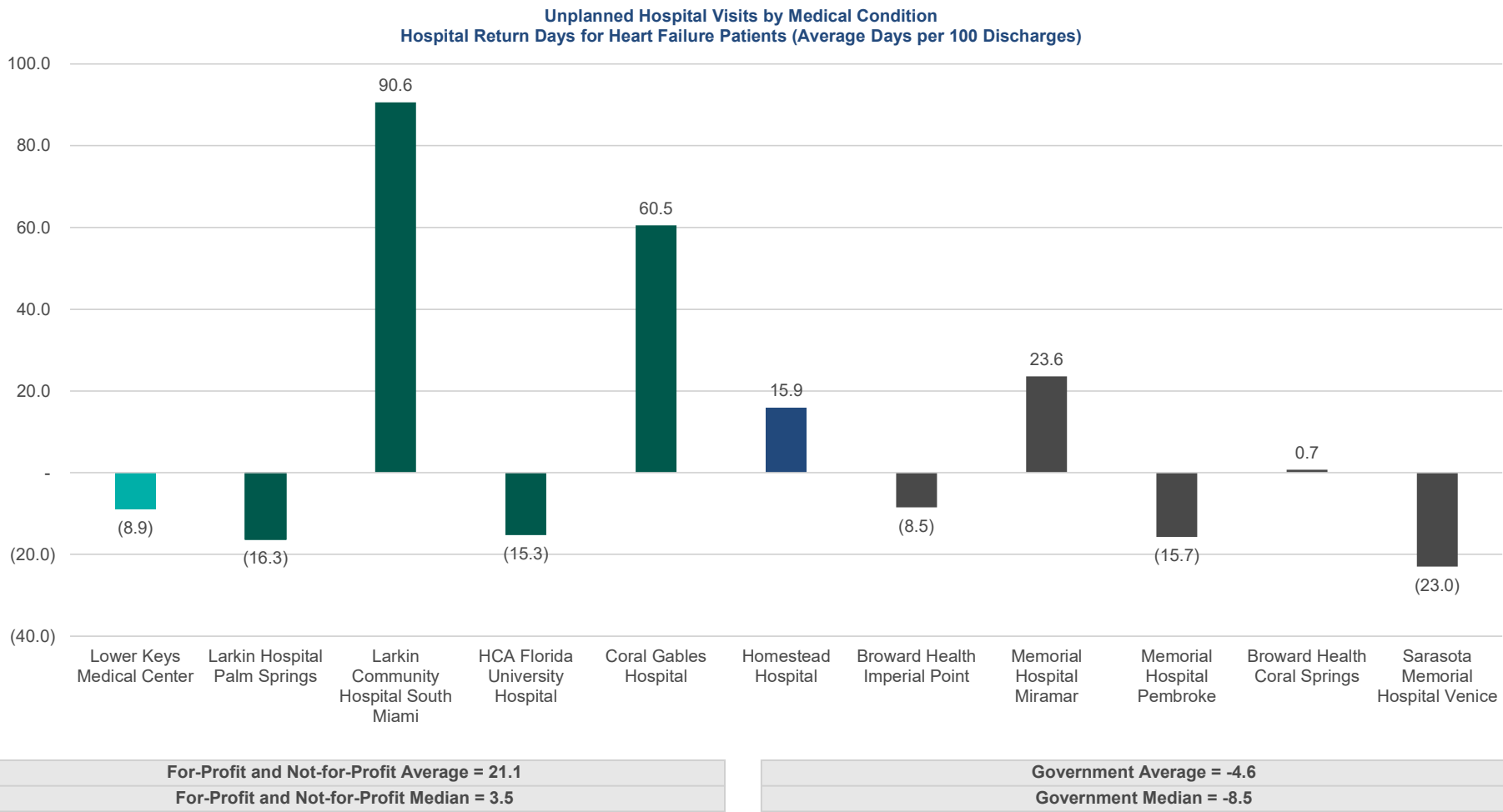
Government Average = 19.9%
Government Median = 19.6%

Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/unplanned-hospital-visits>
- (3) The rates of unplanned readmission focus on whether patients who were discharged from a hospital were hospitalized again within 30 days. Patients may return to the same hospital or to a different hospital. Their readmission might be for a condition that is related to their recent hospitalization, or for a different reason. Rates of unplanned readmission can show whether a hospital is doing its best to prevent complications, provide clear discharge instructions to patients, and help patients make a smooth transition to their home or another setting like a nursing home.



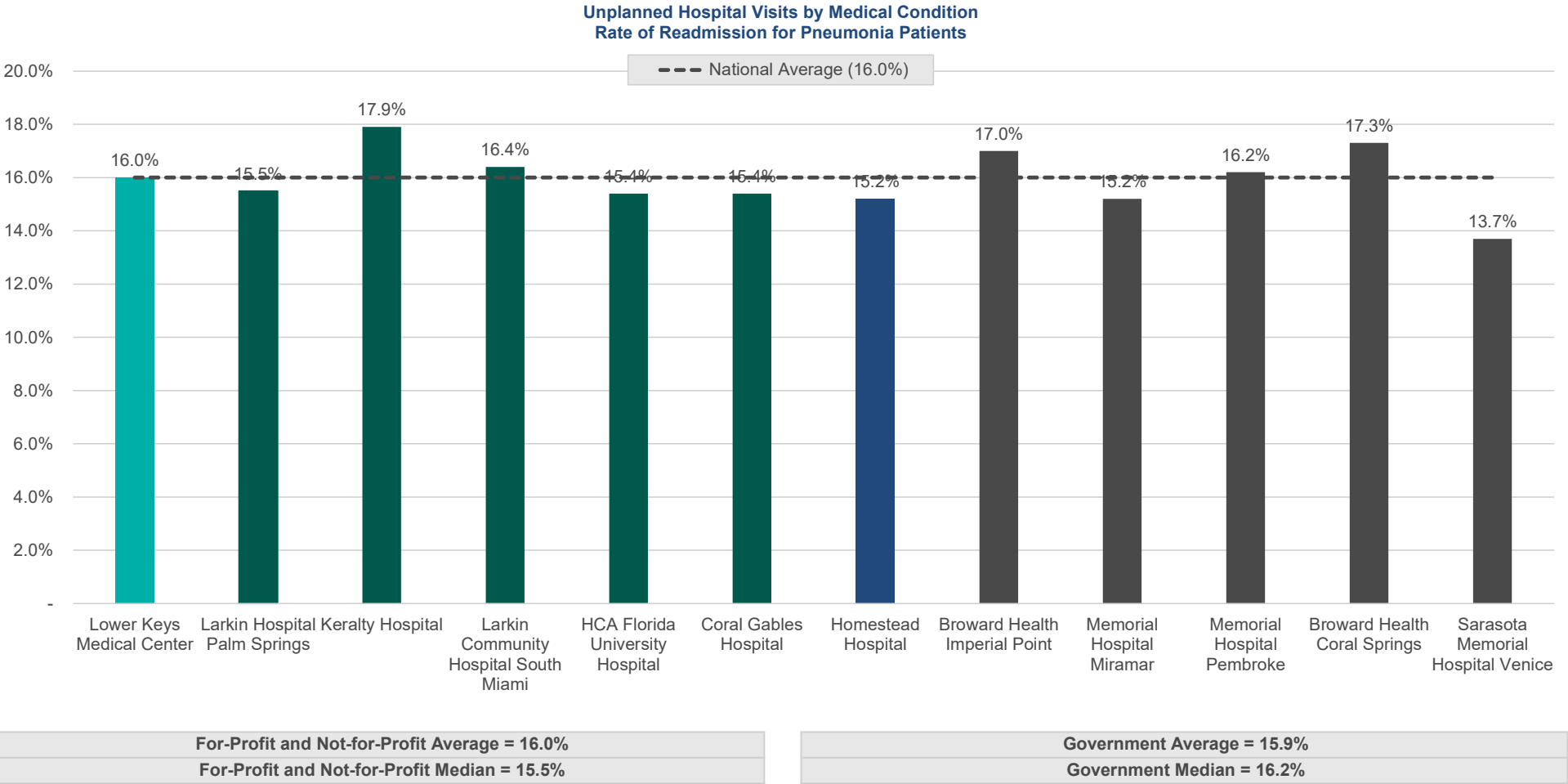


Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
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- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/unplanned-hospital-visits>
- (3) The hospital return days measures add up the days the patient was in an inpatient hospital unit, under observation, or in an emergency department for any unplanned care in the first 30 days after they leave the hospital. The measures compare a hospital's results to the results of an average hospital to determine if the hospital had more days, similar days, or fewer days than the average. Information on hospital return days helps you evaluate a hospital's quality of care based on how much time patients spend back in the hospital during the first 30 days after discharge. For example, hospitals with fewer than average days are likely arranging timely follow-up, ensuring that patients have the proper medicines, and releasing patients into a proper aftercare location.

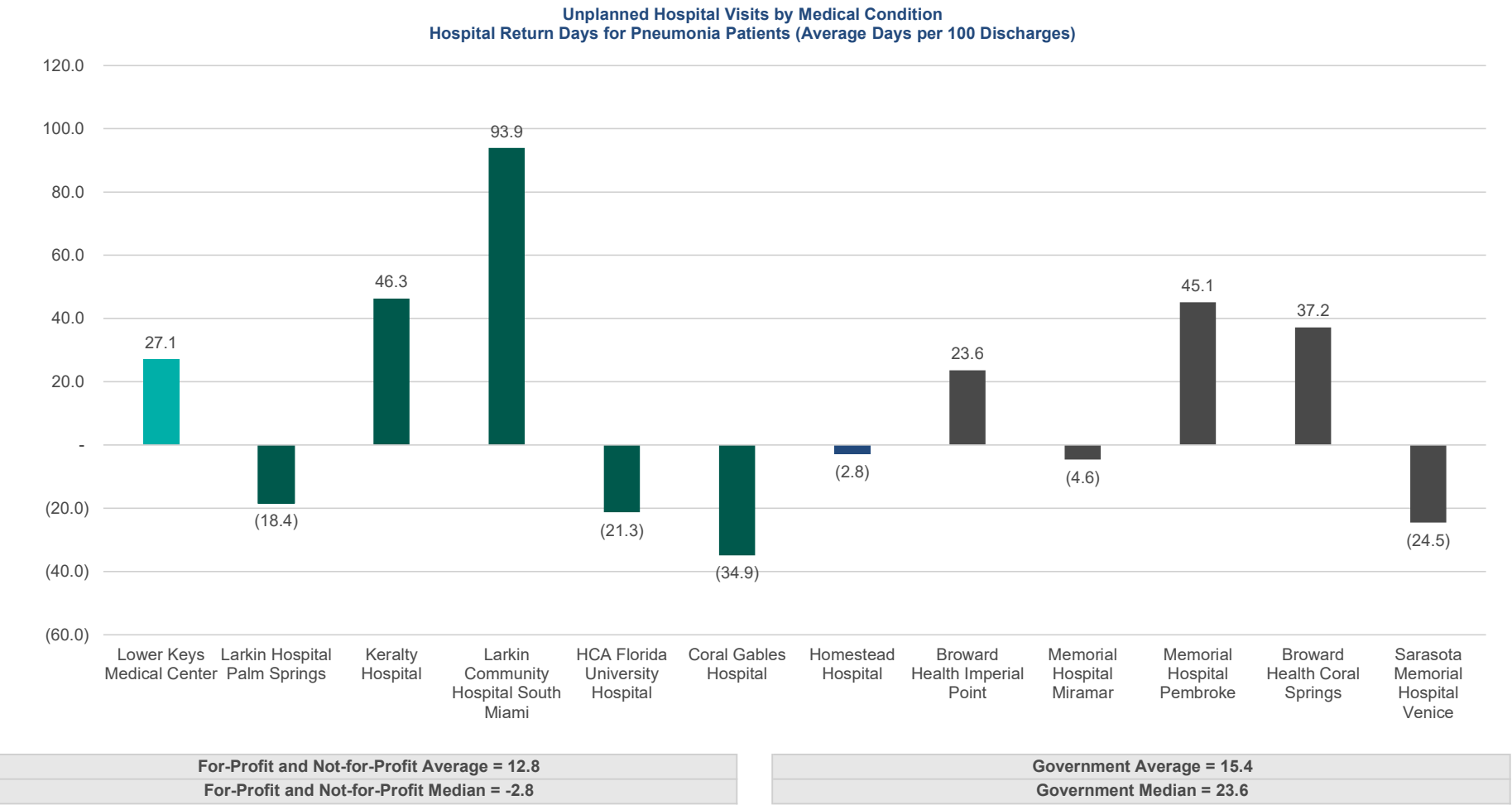




Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
(1) Source(s): https://www.medicare.gov/care-compare/			
(2) Source(s): https://data.cms.gov/provider-data/topics/hospitals/unplanned-hospital-visits			
(3) The rates of unplanned readmission focus on whether patients who were discharged from a hospital were hospitalized again within 30 days. Patients may return to the same hospital or to a different hospital. Their readmission might be for a condition that is related to their recent hospitalization, or for a different reason. Rates of unplanned readmission can show whether a hospital is doing its best to prevent complications, provide clear discharge instructions to patients, and help patients make a smooth transition to their home or another setting like a nursing home.			





Notes and Sources

- Lower Keys Medical Center
- For-Profit Hospitals
- Not-for-Profit
- Government Not-for-Profit
- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/unplanned-hospital-visits>
- (3) The hospital return days measures add up the days the patient was in an inpatient hospital unit, under observation, or in an emergency department for any unplanned care in the first 30 days after they leave the hospital. The measures compare a hospital's results to the results of an average hospital to determine if the hospital had more days, similar days, or fewer days than the average. Information on hospital return days helps you evaluate a hospital's quality of care based on how much time patients spend back in the hospital during the first 30 days after discharge. For example, hospitals with fewer than average days are likely arranging timely follow-up, ensuring that patients have the proper medicines, and releasing patients into a proper aftercare location.



Unplanned Hospital Visits by Procedure
Rate of Readmission After Hip/Knee Replacement

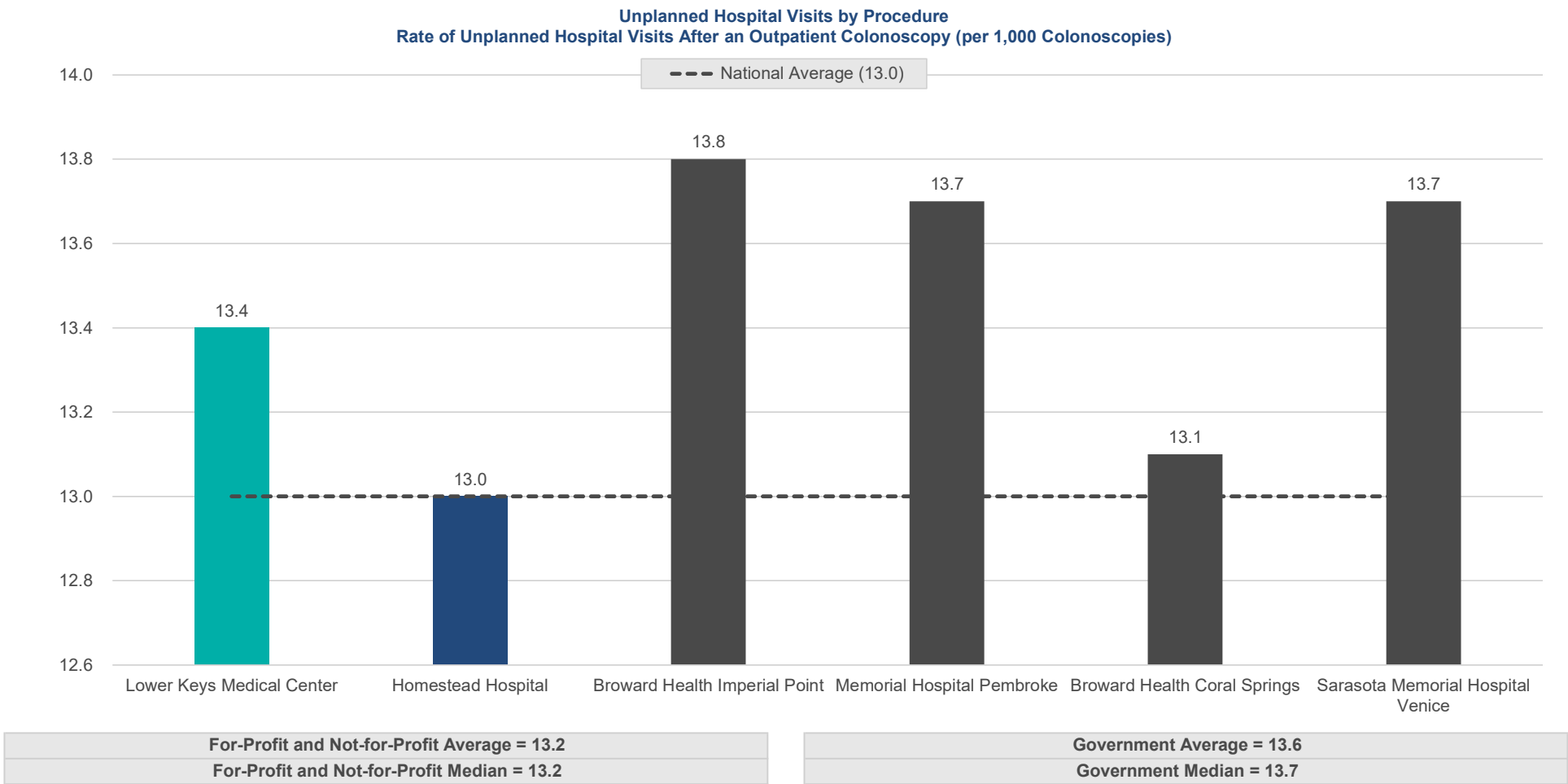


Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
---------------------------	----------------------	----------------	---------------------------

- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/unplanned-hospital-visits>
- (3) The rates of unplanned readmission focus on whether patients who were discharged from a hospital were hospitalized again within 30 days. Patients may return to the same hospital or to a different hospital. Their readmission might be for a condition that is related to their recent hospitalization, or for a different reason. Rates of unplanned readmission can show whether a hospital is doing its best to prevent complications, provide clear discharge instructions to patients, and help patients make a smooth transition to their home or another setting like a nursing home.





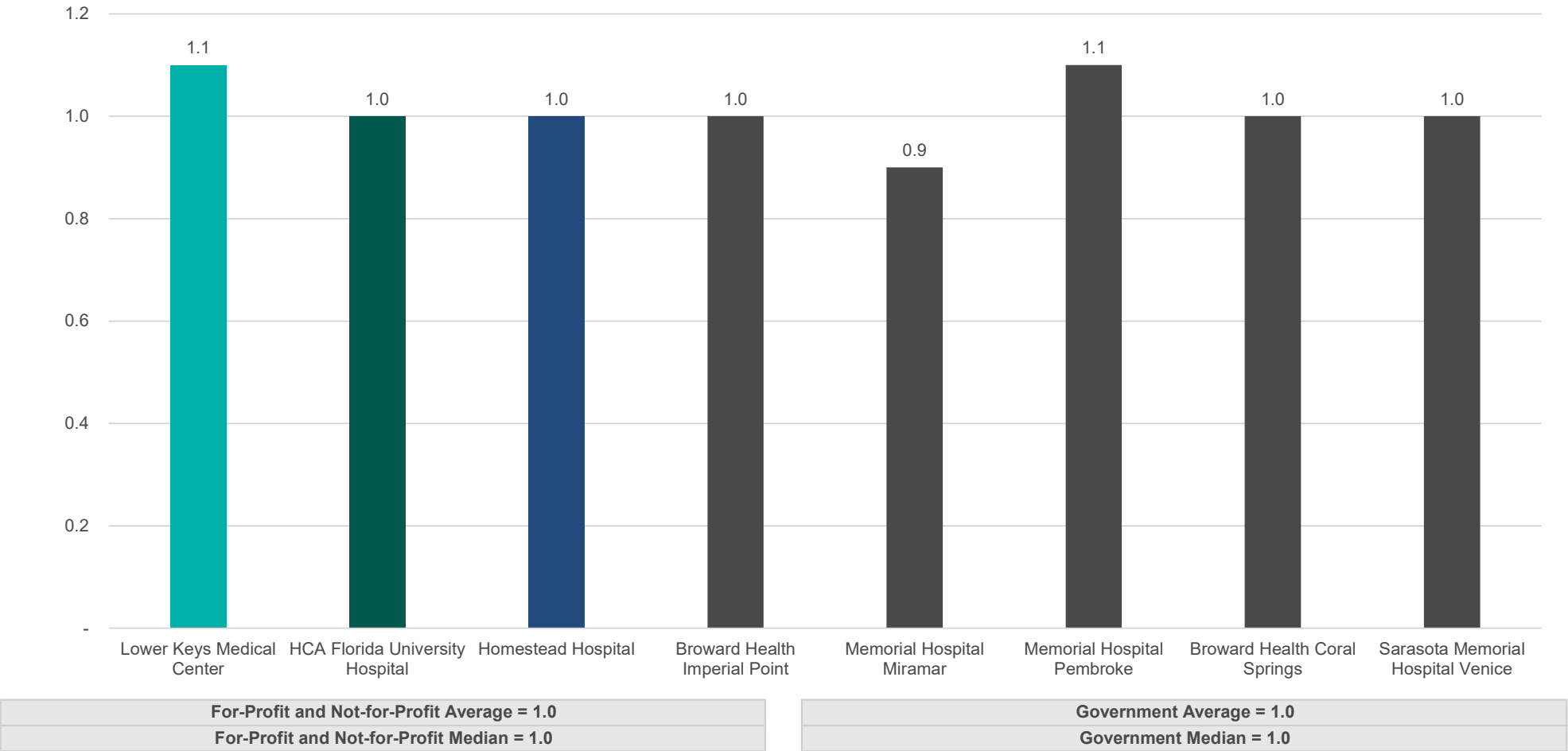
Notes and Sources

Lower Keys Medical Center	For-Profit Hospitals	Not-for-Profit	Government Not-for-Profit
---------------------------	----------------------	----------------	---------------------------

- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/unplanned-hospital-visits>
- (3) A colonoscopy is a test doctors can use to find precancerous polyps (abnormal growths) or colorectal cancer. During a colonoscopy, your doctor can remove any polyps that are found. Outpatient colonoscopies are common procedures that may result in complications, which may lead to unplanned hospital visits. This measure shows the rate of unplanned hospital visits within 7 days of an outpatient colonoscopy. A hospital with lower rates of unplanned hospital visits following colonoscopies may do a better job preparing patients for procedures, avoiding complications, and providing follow-up care. This measure provides the opportunity to improve quality of care and to lower rates of complications leading to hospital visits after outpatient colonoscopy.



Unplanned Hospital Visits by Procedure
Ratio of Unplanned Hospital Visits After Hospital Outpatient Surgery



Notes and Sources

- Lower Keys Medical Center
- For-Profit Hospitals
- Not-for-Profit
- Government Not-for-Profit
- (1) Source(s): <https://www.medicare.gov/care-compare/>
- (2) Source(s): <https://data.cms.gov/provider-data/topics/hospitals/unplanned-hospital-visits>



Final Report

Lower Keys Medical Center

Community Benefit Analysis

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Community Benefit Analysis	Low	Midpoint	High	Key Assumptions
1. Uncompensated Care Cost				
Cost of Charity	\$48,642,852	\$48,642,852	\$48,642,852	FY 2025 per Hospital management representation
Cost of Bad Debt	\$15,438,094	\$15,438,094	\$15,438,094	= 11.0% of NBY Total Net Fee-for-Service Revenue
Total Uncompensated Care Cost	\$64,080,946	\$64,080,946	\$64,080,946	
Support Provided by the County Board				
Annual Indigent Care Subsidy	(\$1,500,000)	(\$1,500,000)	(\$1,500,000)	
Indigent Care to Participating Physicians	(\$500,000)	(\$500,000)	(\$500,000)	
Total Support Provided by the County Board	(\$2,000,000)	(\$2,000,000)	(\$2,000,000)	
Uncompensated Care Cost, Net of Support Provided by the County Board	\$62,080,946	\$62,080,946	\$62,080,946	= Uncompensated Care Cost – Support Provided by the County Board
2. Estimated Property Taxes Paid Under Hypothetic For-Profit Buyer				Notes and Sources (1)
Hospital's Just (Market) Value	TBD	\$8,000,000	TBD	
Ad Valorem Taxes	TBD	\$65,800	TBD	
Non-Ad Valorem Taxes	TBD	\$30,664	TBD	
Total Estimated Property Taxes Paid Under Hypothetic For-Profit Buyer	TBD	\$96,464	TBD	
4. Estimated Proceeds from Sale of the Hospital	\$128,207,000	\$168,707,000	\$209,307,000	See Page 20 for the Fair Market Value Analysis of the Hospital

The operation of the Hospital by an entity that is not the District is a net benefit to the community, assuming a hypothetical buyer maintains the Hospital's current charity and bad debt levels, currently represented at \$48.6 million and \$14.0 million, respectively, annually. Although the support provided by the District could be used for other purposes within the county, the amount currently provided is relatively insignificant compared to the Total Uncompensated Care provided by the Hospital. We also understand the current level of property taxes paid by the Hospital is estimated at approximately \$96,000 annually according to the Hospital's 2025 estimated property tax level published on the county's tax collector website. However, property taxes may be higher and or lower depending on what is negotiated in the future lease and whether the tax assessment of the facility is updated. In addition, the Hospital may generate sales and other types of taxes, licenses, and fees from a hypothetical operator. Finally, the estimated proceeds from the sale of the Hospital may be significant from the lease of the Hospital and used to create an indigent care fund and/or health care economic fund to the benefit of the local community.

Notes and Sources

(1) Source(s): <https://county-taxes.net/fl-monroe/property-tax/bW9ucm9lOnJlYWxfZXN0YXRlOnBhcmVudHM6ZWYxYTEzODktZTUwOS0xMWVlTk0NjctMDA1MDU2ODE4NzEw>



Final Report

Lower Keys Medical Center

Qualifications and Certification

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Statement of Limiting Conditions

The Conclusion(s) of Value in this report are qualified as follows:

- **Reliance on Data Provided by Client:** The facts described in this Summary Report were provided by management or obtained from independent third parties including the Hospital's accountants, published sources, and commercial databases. VMG accepted this information without verification, and assume this information is materially true and correct.
- **Going Concern Value:** The Conclusion(s) of Value assumes competent management in the context of a going concern value.
- **Client Compliance with Laws:** Certain matters are outside the purview of VMG's expertise. As a result, the Conclusion(s) of Value assume (1) the Hospital complies fully with all federal, state, and local laws and ordinances; (2) funding for pensions and healthcare liabilities, if any, is adequate; and (3) there are no undisclosed factors that might render the Hospital materially more or less valuable. Any statements in this Summary Report about the above issues are based on management representations. Client is responsible for any differences and any impact on the Conclusion(s) of Value.
- **Client of Record; Use and Disclosure of Summary Report; No Third-Party Reliance:** Only Client is the intended user of and may rely on this Summary Report. Client may not substitute the Summary Report for its own due diligence. Client may provide a copy of the Summary Report to its legal counsel, federal or state regulatory authorities, as required by law, or to other third-party advisors, provided such third-party advisors execute a third-party access letter, which shall be timely and not unreasonably withheld. Receipt or use of the Summary Report by any third party does not create any third-party beneficiary rights. Client is a public entity, and as such, the Summary Report will be subject to Florida's public records law once it is provided by Counsel to Client.
- **No Assurance of Forecasts:** VMG has not examined the historical, interim, or prospective financial statements according to generally accepted auditing standards, and so expresses no opinion thereon in this Summary Report. Actual operating results may vary materially from those described.
- **Valuation Engagement Methods:** Any estimates of future performance in this Summary Report or associated exhibits relate to specific Valuation Engagement methods. These methods match performance scenarios with their associated risk rates to quantify the Valuation Engagement parameters. Using the future performance scenarios or discount rate separately, or outside the Valuation Engagement context, is unauthorized and prohibited.
- **Value Synergies:** Synergies and cost savings, if any, incorporated into the projections were believed to be realizable by any hypothetical and willing market participant. VMG excluded buyer-specific synergies from the analysis to be consistent with the definition of FMV.
- **The fee for this assignment is provided only for the preparation of this Summary Report for the specific Valuation Date.** All other services including (1) updates to the Conclusion(s) of Value for any other date; (2) preparation and testimony in court or before governmental agencies; or (3) meetings about the Summary Report after its delivery will be provided at additional cost for fees and expenses.



Appraiser's Certification

I certify that, to the best of my knowledge and belief:

- The statements of fact contained in this Summary Report are true and correct.
- The Summary Report analysis, opinions, and Conclusion(s) of Value are limited by the reported assumptions and limiting conditions and represent my personal, impartial, and unbiased professional analysis, opinions, and conclusions.
- I have no present or prospective interest in the assets that are the subject of this Summary Report and no personal interest with respect to the parties involved.
- I have no bias with respect to the assets that are the subject of this Summary Report or to the parties involved with this assignment.
- My engagement in this assignment was not contingent on developing or reporting predetermined results.
- My compensation for completing this assignment is not contingent on the development or reporting of a predetermined value or direction in value that favors the cause of the Client, the amount of the value opinion, the attainment of a stipulated result, or the occurrence of a subsequent event directly related to the intended use of this Valuation Engagement.
- I have performed no services, as an appraiser or in any other capacity, regarding the property that is the subject of this Summary Report other than prior services that have been fully disclosed to the Client.
- I have not personally inspected the subject property of this Summary Report.
- No persons other than the undersigned or those acknowledged in this Summary Report prepared analysis, values, and Conclusion(s) of Value set forth in this Summary Report.
- This Summary Report was completed in accordance with the National Association of Certified Valuation Analysts Professional Standards.

William Teague

Certifying Appraiser: William Teague, CFA, CVA

Other Contributing Appraisers: Colin McDermott, CFA, CPA/ABV, Madi Whyde and Maggie Perry



Final Report

Lower Keys Medical Center

Appendix

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VMG has relied on information provided directly from the Hospital's management as well as information obtained from independent data sources. The following list summarizes the information VMG has relied upon in forming our opinion:

Information provided by the Hospital:
• Unaudited historical balance sheets for LKMC (inclusive of ancillary and DePoo operations) as of December 31, 2022, 2023, 2024, and 2025 provided in the following files: • "Lower Keys Balance Sheet 2022 - Summary CY PY.pdf" • "Lower Keys Balance Sheet 2023 - Summary CY PY.pdf" • "D.2 Lower Keys Balance Sheet 2025 - Summary CY PY.pdf" • Unaudited historical balance sheets for LKMC (inclusive of Depoo operations) as of December 31, 2024, and 2025 provided in the following files: • "Lower Keys_Hosp Only_Balance Sheet 2025.pdf" • Unaudited historical income statements for LKMC (inclusive of ancillary and DePoo operations) for FY 2022, FY 2023, FY 2024, and FY 2025 provided in the following files: • "Lower Keys Income Statement 2022_12 Month Summary Report.pdf" • "Lower Keys Income Statement 2023_12 Month Summary Report.pdf" • "Lower Keys Income Statement 2024_12 Month Summary Report.pdf" • "D.2 Lower Keys Income Statement 2025_12 Month Summary Report.pdf" • Unaudited historical income statements for LKMC (inclusive of DePoo operations) for FY 2024 and FY 2025 provided in the following files: • "Lower Keys_Hosp Only_Income Statement 2024.pdf" • "Lower Keys_Hosp Only_Income Statement 2025.pdf" • Unaudited historical income statements for DePoo for FY 2024 and FY 2025 provided in the following files: • "Lower Keys IP Psych Department (DePoo) Income Statement - YTD 12-24.pdf" • "Lower Keys IP Psych Department (DePoo) Income Statement - YTD 12-25.pdf"



VMG has relied on information provided directly from the Hospital's management as well as information obtained from independent data sources. The following list summarizes the information VMG has relied upon in forming our opinion:

Information provided by the Hospital:
- Audited historical financial statements for the District for FY 2023, FY 2024, and FY 2025 provided in the following files: "LFKHD Board FYE 2023 Draft Financial Statements.pdf" "FY24 Draft LFKHD Board Draft Financials.pdf" "FY25 Draft Financial Statements.pdf" - Unaudited historical budgets for LKMC (inclusive of DePoo and ancillary operations for FY 2023, FY 2024, and FY 2025 provided in the following files: "LOKY Budget 2023-2025_BL.pdf" - Unaudited production and operating reports for LKMC (inclusive of Depoo and ancillary operations) for FY 2022, FY 2023, FY 2024, and FY 2025 provided in the following files: "E.1 Stats.xlsx" "LOKY D26 Rev & Admits by Payor 2023-2025.xlsx" - Facility lease information provided in the following files: - Lease Agreement by and between The Lower Florida Keys Hospital District and Key West HMA, Inc., dated May 1, 1999, provided by Client in the file "LFKHD LeaseAgreement 1999 05 01.pdf" - Lease Agreement Amendment by and between The Lower Florida Keys Hospital District and Key West HMA, Inc., dated October 1, 2001, provided by Client in the file "LFKHD Lease Agreement Amendment One 2002 04 15.pdf" - Second Lease Agreement Amendment by and between The Lower Florida Keys Hospital District and Key West HMA, Inc., dated October 1, 2003, provided by Client in the file "LFKHD Lease Agreement Amendment Two 2003 10 01.pdf"



VMG has relied on information provided directly from the Hospital's management as well as information obtained from independent data sources. The following list summarizes the information VMG has relied upon in forming our opinion:

Information provided by the Hospital:
• Additional facility information provided in the following files: • Lower Keys Medical Center 2026 Facility Condition Assessment provided by District in the file "BLKMC_Lower Keys Medical Center_ISES Corp FCA.pdf" • "LKMC_30-Year Recurring Needs_2026-03-03.xlsx" • "LKMC & Depoo - Historical & Current Project Spending - Master Spreadhseet_2026-06-16.xlsx" • Organizational documents including • Draft Request for Proposal ("RFP") provided by Client in the file "Draft RFP LFKHD CLEAN DRAFT 6.2.26.docx" • "1(g) - Mgmt Fee and Allocation Summary.xlsx" • Fixed asset listing provided in the following files: • "Fixed Asset Listing for 1005 as of 12.31.25.xlsx" • Provider roster provided in the following files: • "F.1 LKMC Med Staff Feb 10 2026.xlsx" • Management interviews



VMG has relied on information provided directly from the Hospital's management as well as information obtained from independent data sources. The following list summarizes the information VMG has relied upon in forming our opinion:

Other information sources including, but not limited to, these:
- Florida Senate Bill Summaries (https://flsenate.gov/Committees/bills/summaries/2012/html/711) 2024 Florida Statutes (Including 2025C) (https://www.flsenate.gov/Laws/Statutes/2024/155.40) - U.S. Census Bureau - Centers for Medicare & Medicaid Services - U.S. Bureau of Labor Statistics - U.S. Bureau of Economic Analyses - Federal Reserve Statistical Releases - Office of Management and Budget - Congressional Budget Office - Federal Reserve Bank of Philadelphia, Survey of Professional Forecasters - Public company SEC filings - Federal Register - Irving Levin Associates database - DealStats - Mergerstat Review - ScopeResearch



VMG has relied on information provided directly from the Hospital's management as well as information obtained from independent data sources. The following list summarizes the information VMG has relied upon in forming our opinion:

Other information sources including, but not limited to, these:
• <i>The Market Approach to Valuing Businesses, 2nd Edition</i> by Shannon P. Pratt • <i>Cost of Capital: Estimation and Applications, 2nd Edition</i> by Shannon P. Pratt • <i>Valuing a Business, 5th Edition</i> by Shannon P. Pratt with Alina V. Niculita • S&P's Capital IQ • 2025 State Corporate Income Tax Rates: https://taxfoundation.org/data/all/state/state-corporate-income-tax-rates-brackets/ • 2025 Section 179 Thresholds: https://www.irs.gov/pub/irs-drop/rp-24-40.pdf • Proprietary internal database of acute care hospital transactions





Experience

William Teague is a director based in the Nashville office. Mr. Teague specializes in providing valuation, transaction advisory, and consulting services to the healthcare industry. He has been involved in over 200 engagements working with acute care hospitals, radiation/proton therapy centers, inpatient rehabilitation facilities, behavioral health hospitals, ambulatory surgery centers, diagnostic imaging facilities, physician practices, home health agencies and numerous other ancillary service businesses.

Projects include valuations in support of transactions, joint ventures, recapitalizations and for financial reporting purposes. In addition, he regularly performs valuations of specific intangible assets including health system trade names, certificates of need (CON) and non-compete agreements. Mr. Teague has also consulted with clients to assess the market and feasibility of denovo facilities, potential joint ventures and other investment projects. Finally, he has an extensive background in physician compensation arrangements.

William Teague, CFA

Managing Director

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Nashville, Tennessee 37201

+ More About Me

Mr. Teague graduated summa cum laude and holds a Bachelor of Science in Finance and Economics from the University of Tennessee at Knoxville. He holds the Chartered Financial Analyst (CFA) designation and is currently pursuing the Certified Valuation Analyst (CVA) designation.

Areas of Expertise

M&A and Transaction Advisory
Valuation Advisory



Final Report

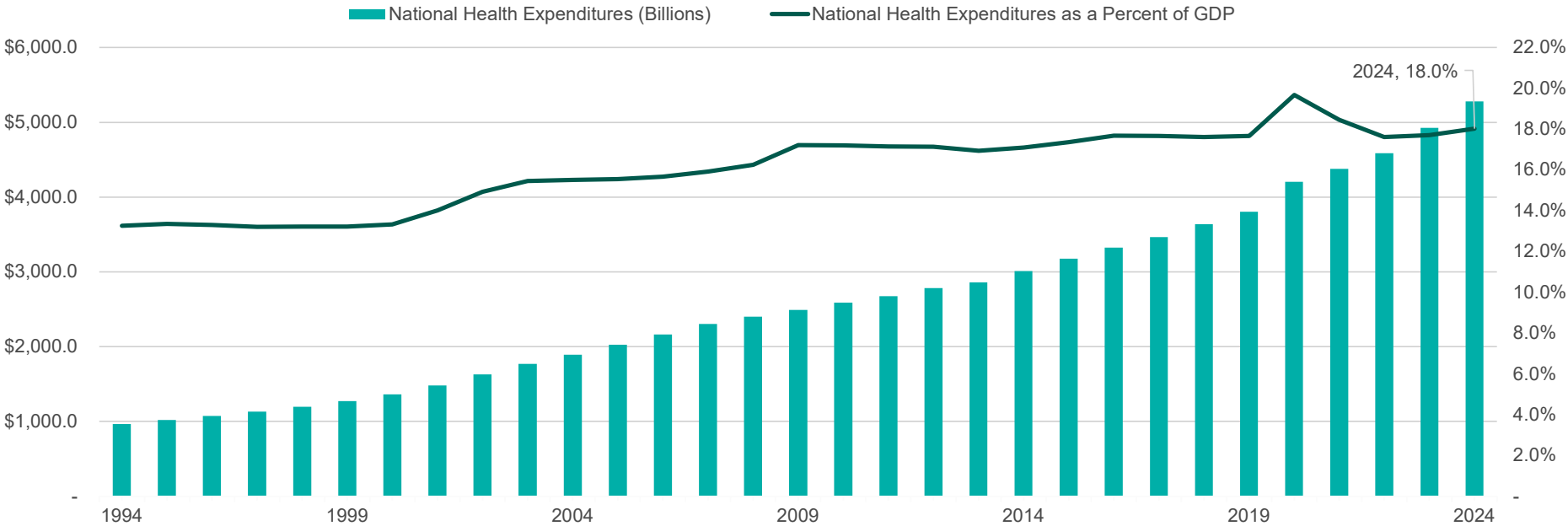
Lower Keys Medical Center

United States Healthcare System

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United States Healthcare System

According to the Centers for Medicare & Medicaid Services ("CMS"), total national healthcare expenditures over the last 30 years have grown at a compound annual growth rate of 5.8% from approximately \$966.4 billion in 1994 to approximately \$5,278.6 billion in 2024. Most recently, total national health expenditures grew 7.2% from approximately \$4,925.3 billion in 2023 to approximately \$5,278.6 billion in 2024. Healthcare spending as a percent of gross domestic product ("GDP") over the last 30 years has increased from a low of 13.2% in 1997 to a high of 19.7% in 2020. More recently, healthcare spending was approximately 18.0% of GDP in 2024, an increase of approximately 1.7% from 2023 healthcare spending as a percent of GDP of approximately 17.7%.



Notes and Sources

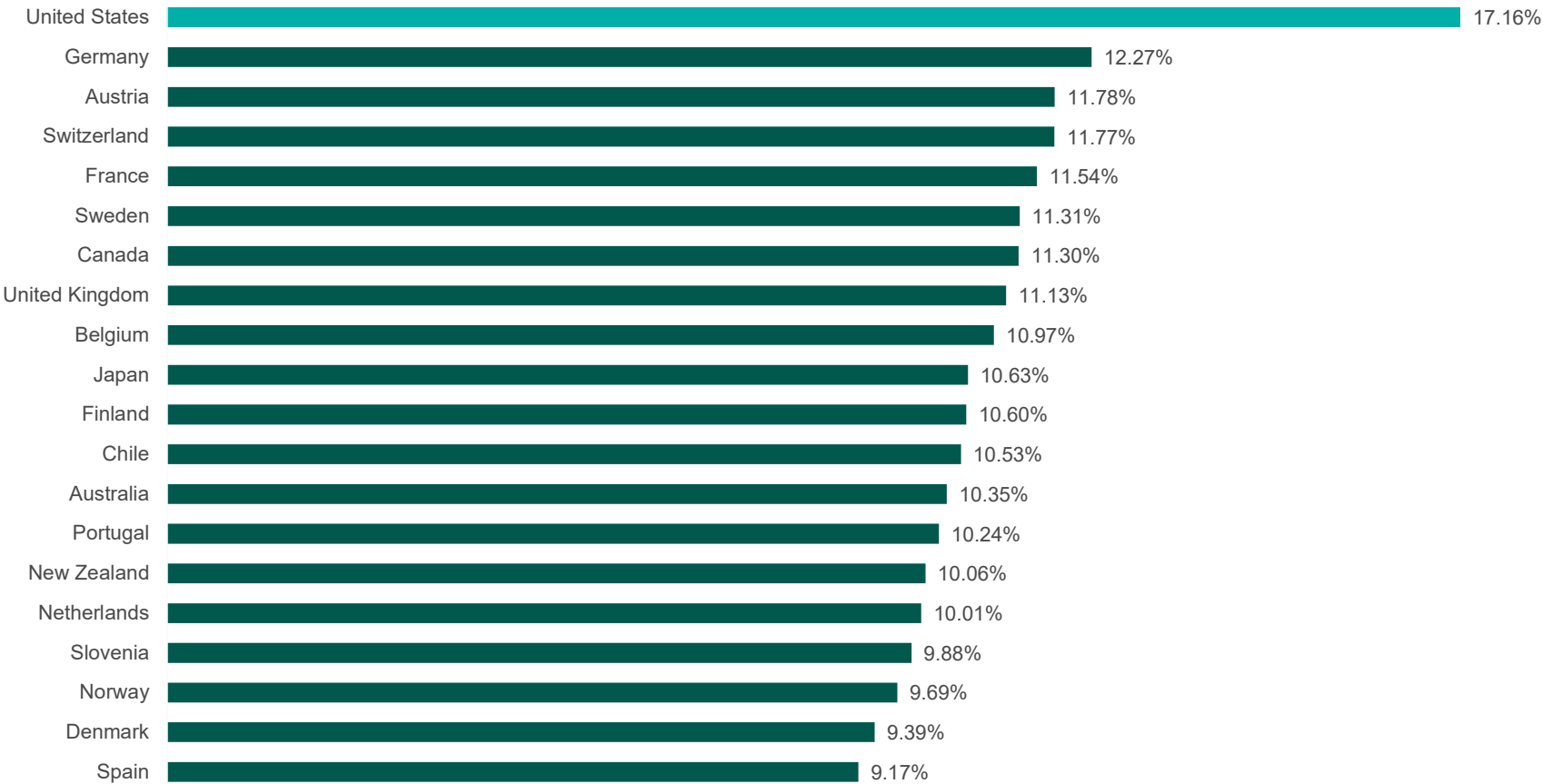
- (1) Source(s): Table 1. National Health Expenditures; Aggregate and per Capita Amounts, Annual Percent Change, and Percent Distribution. Calendar Years 1960 to 2024. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census. <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical>
- (2) Source(s): National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2024. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical>
- (3) Source(s): Federal Reserve Bank of St. Louis, National Bureau of Economic Research ("NBER")-Based Recession Indicators for the United States from the Period following the Peak through the Trough ("USREC"). FRED, Federal Reserve Bank of St. Louis. Data retrieved December 8, 2025. <https://fred.stlouisfed.org/series/USREC>



United States Healthcare System

According to the Organisation for Economic Co-Operation and Development ("OECD"), the United States spends more on healthcare, both per capita, and as a share of GDP, than any other country in the world. The chart below presents the top twenty OECD countries in terms of annual health spending as a percent of GDP in 2024.

Annual Health Expenditure and Financing as a Percent of Gross Domestic Product, 2024



Notes and Sources

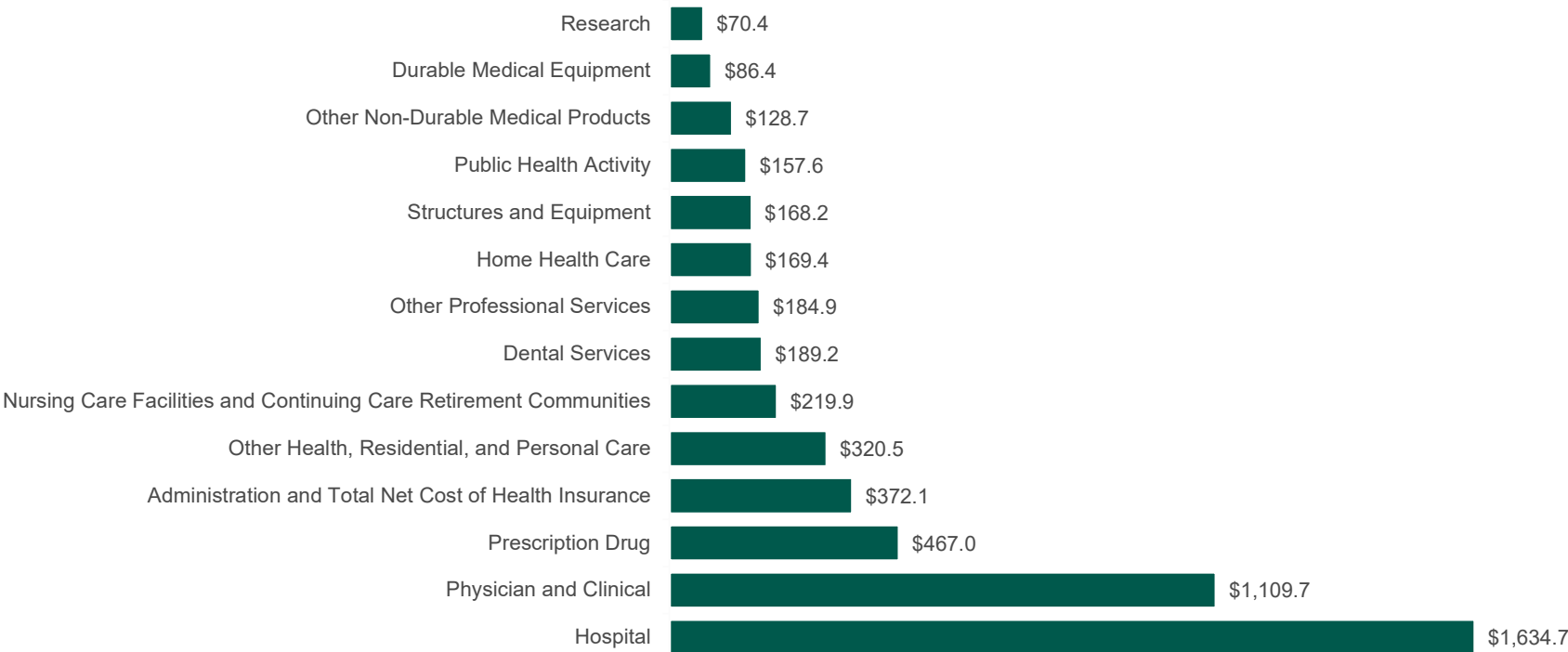
(1) Source(s): Organisation for Economic Co-Operation and Development. Data retrieved February 9, 2026. <https://stats.oecd.org/Index.aspx?DataSetCode=SHA#>



United States Healthcare System

From 2023 to 2024 total national health expenditures increased 7.2% from approximately \$4,925 billion in 2023 to approximately \$5,279 billion in 2024. In 2024 Hospital and Physician and Clinical were the largest spending categories, accounting for approximately \$2,744 billion, or 52.0%, of total health expenditures. From 2014 to 2024 overall healthcare spending increased at a compound annual growth rate of approximately 5.8%. Over this time frame, Other Professional Services and Other Health, Residential, and Personal Care experienced the largest growth in spending, at compound annual growth rates of approximately 8.4% and 7.3%, respectively, from 2014 to 2024.

National Health Expenditures by Category, 2024 (Billions)



Notes and Sources

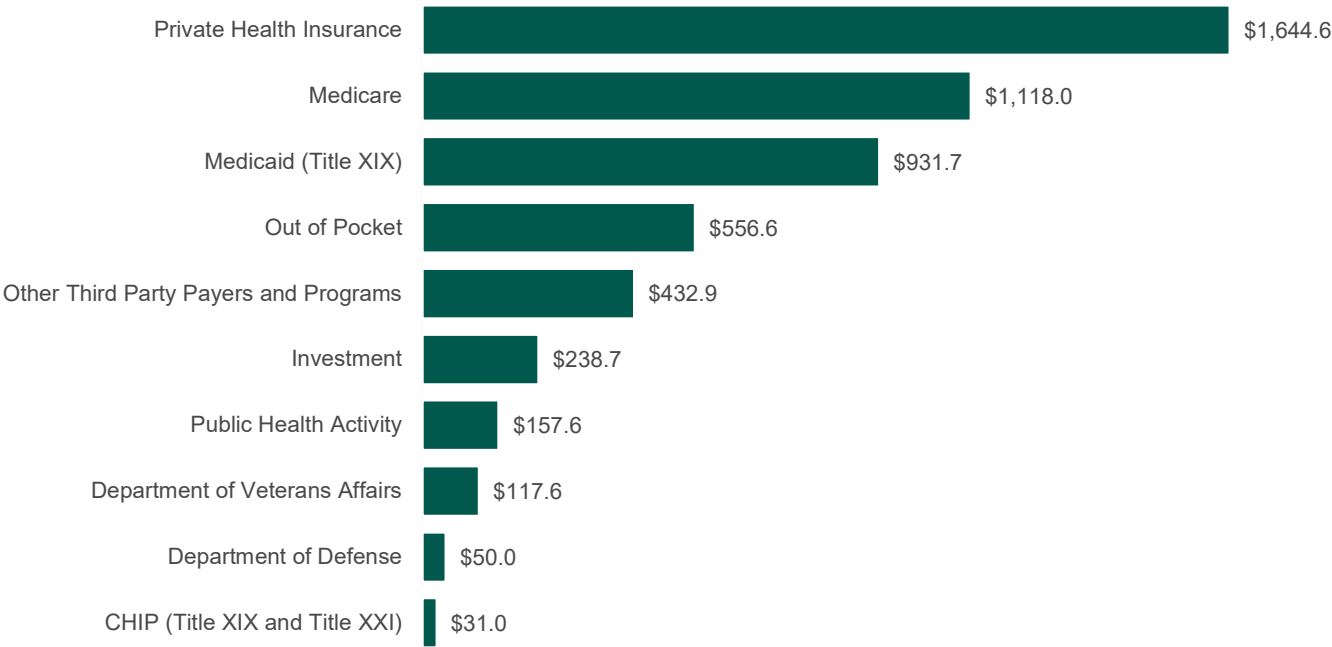
(1) Source(s): National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2024. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical>



United States Healthcare System

Multiple private and public sources combine to finance healthcare expenditures in the United States. Overall public sources of funding (CHIP (Title XIX and Title XXI), Department of Defense, Department of Veterans Affairs, Public Health Activity, Investment, Medicaid (Title XIX), Medicare) accounted for approximately 50.1% of national health expenditures during 2024.

National Health Expenditures by Payor, 2024 (Billions)



Notes and Sources

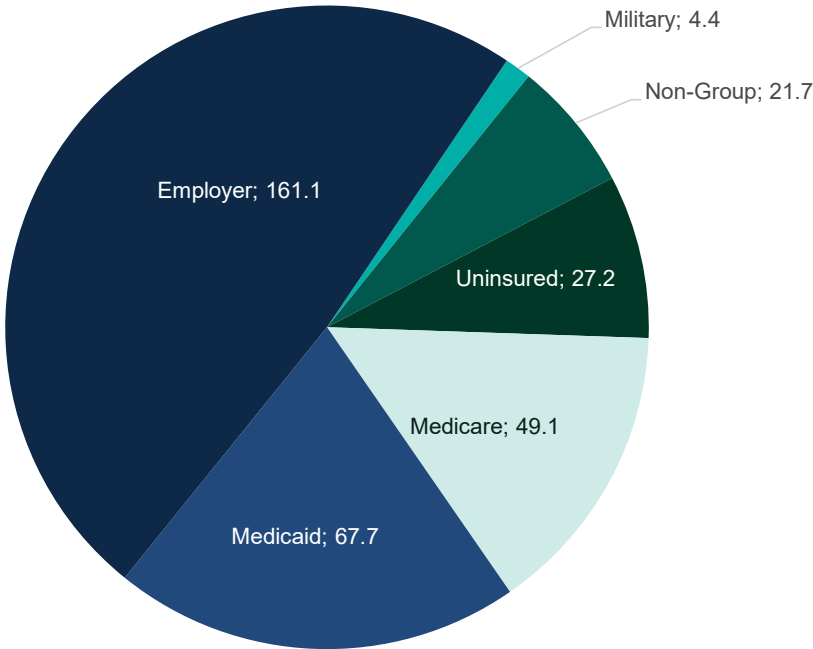
(1) Source(s): National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2024. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical>



United States Healthcare System

Most Americans under the age of 65 have health coverage through a private insurance provider. According to the Kaiser Family Foundation ("KFF"), during 2024 approximately 48.6% of Americans had Employer-based private insurance, while approximately 6.6% obtained private insurance through the individual plan market. The largest government payors, Medicaid and Medicare, covered approximately 20.4% and 14.8% of Americans, respectively, in 2024.

Health Insurance Coverage of the Total Population, 2024 (Millions)



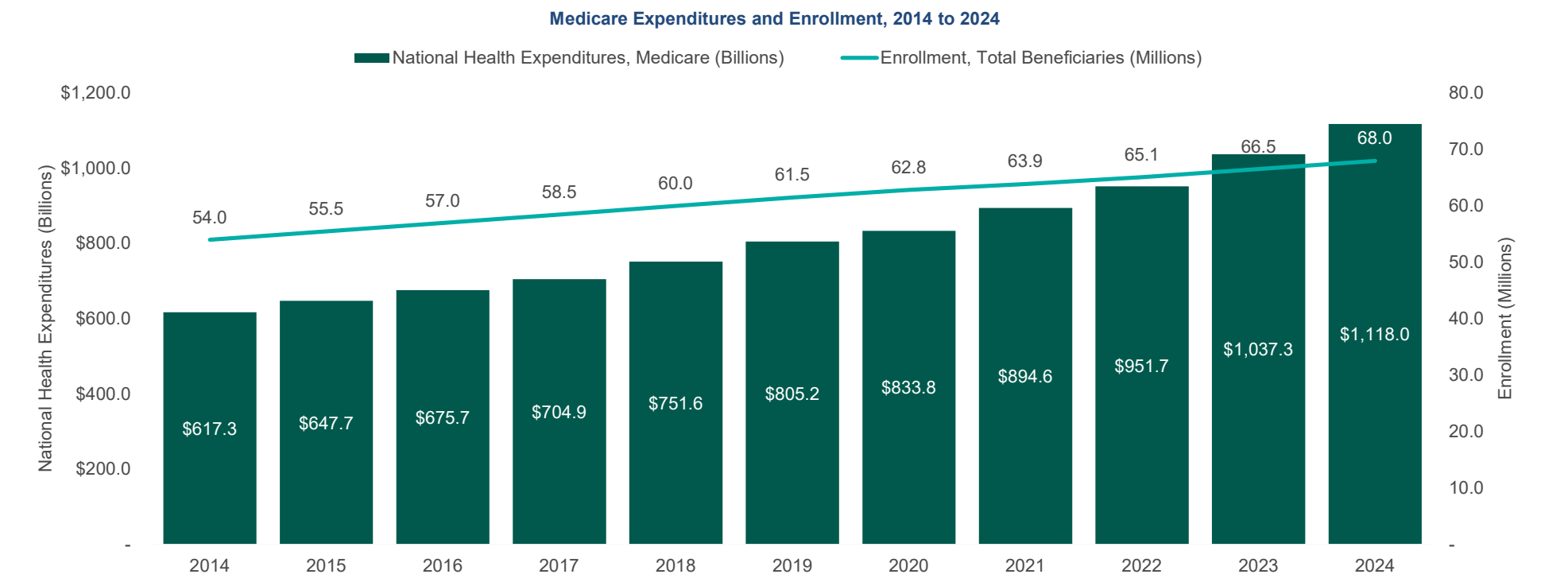
Notes and Sources

- (1) Source(s): Kaiser Family Foundation ("KFF") estimates based on the 2008-2023 American Community Survey, 1-Year Estimates. Data retrieved February 9, 2026. <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- (2) The count of people with Medicare excludes those who report having both Medicare and Medicaid coverage, also known as dual eligibles. If these individuals were instead categorized as having Medicare, the total number of people with Medicare would increase.



United States Healthcare System

As of October 2025, Medicare provides federal health insurance for approximately 69.6 million beneficiaries who are elderly, disabled, have end-stage renal disease, or amyotrophic lateral sclerosis (also known as Lou Gehrig's disease). Individuals become eligible for Medicare when they reach the age of 65; certain disabled individuals also become eligible for Medicare 24 months after they become eligible for benefits under the Social Security Disability Insurance Program. Since 2014, Medicare spending has grown approximately 6.1% compounded annually from approximately \$617.3 billion in 2014 to approximately \$1,118.0 billion in 2024. More recently, total Medicare spending increased 7.8% from approximately \$1,037.3 billion in 2023 to approximately \$1,118.0 billion in 2024.



Notes and Sources

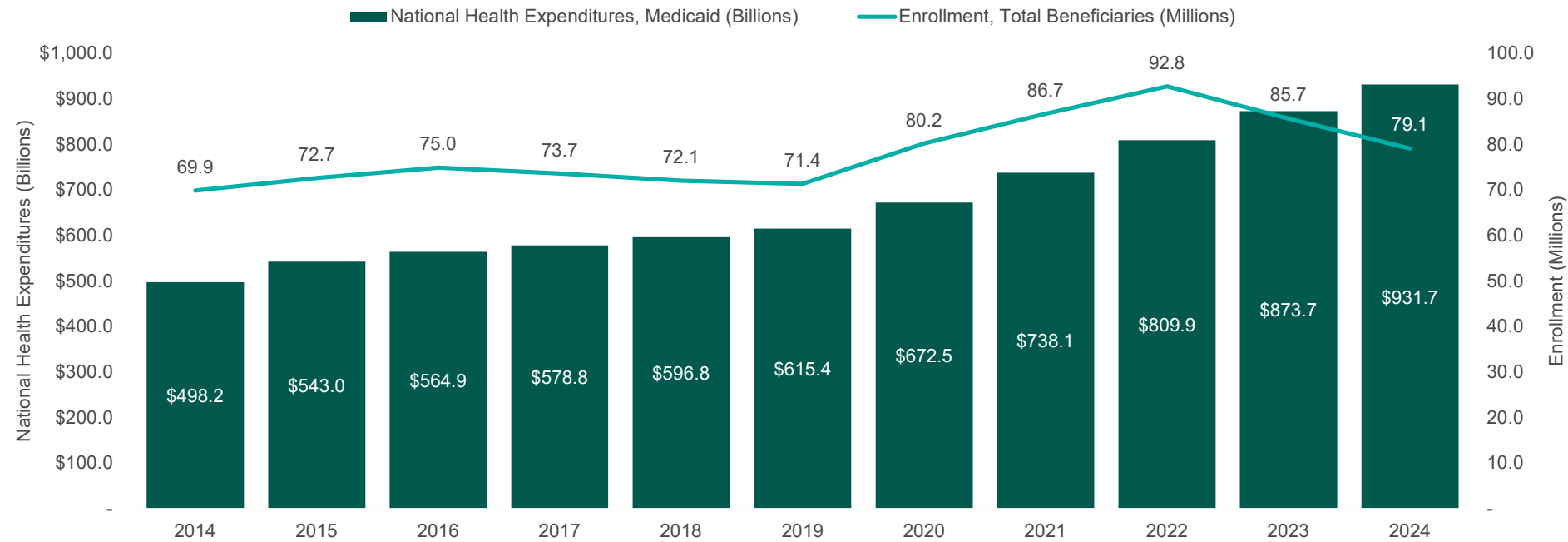
- (1) Source(s): National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2024. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical>
- (2) Source(s): Medicare Monthly Enrollment, Centers for Medicare & Medicaid Services. Data retrieved February 9, 2026. <https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment>



United States Healthcare System

Medicaid is a joint federal-state program that pays for healthcare services for a variety of low-income individuals. The Medicaid program, created in 1965 by the same legislation that created Medicare, replaced an earlier program of federal grants given to states to provide medical care to low-income residents. As of September 2025, approximately 77.1 million people were enrolled in the Medicaid program. It should be noted that certain individuals, often referred to as dual-eligible, are covered by both Medicaid and Medicare. Since 2014, Medicaid spending has grown 6.5% compounded annually from approximately \$498.2 billion in 2014 to approximately \$931.7 billion in 2024.

Medicaid Expenditures and Enrollment, 2014 to 2024



Notes and Sources

- (1) Source(s): National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2024. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical>
- (2) Source(s): "Total Monthly Medicaid & CHIP Enrollment and Pre-ACA Enrollment." KFF. Data retrieved January 13, 2026. <https://www.kff.org/affordable-care-act/state-indicator/total-monthly-medicare-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>



Final Report

Lower Keys Medical Center

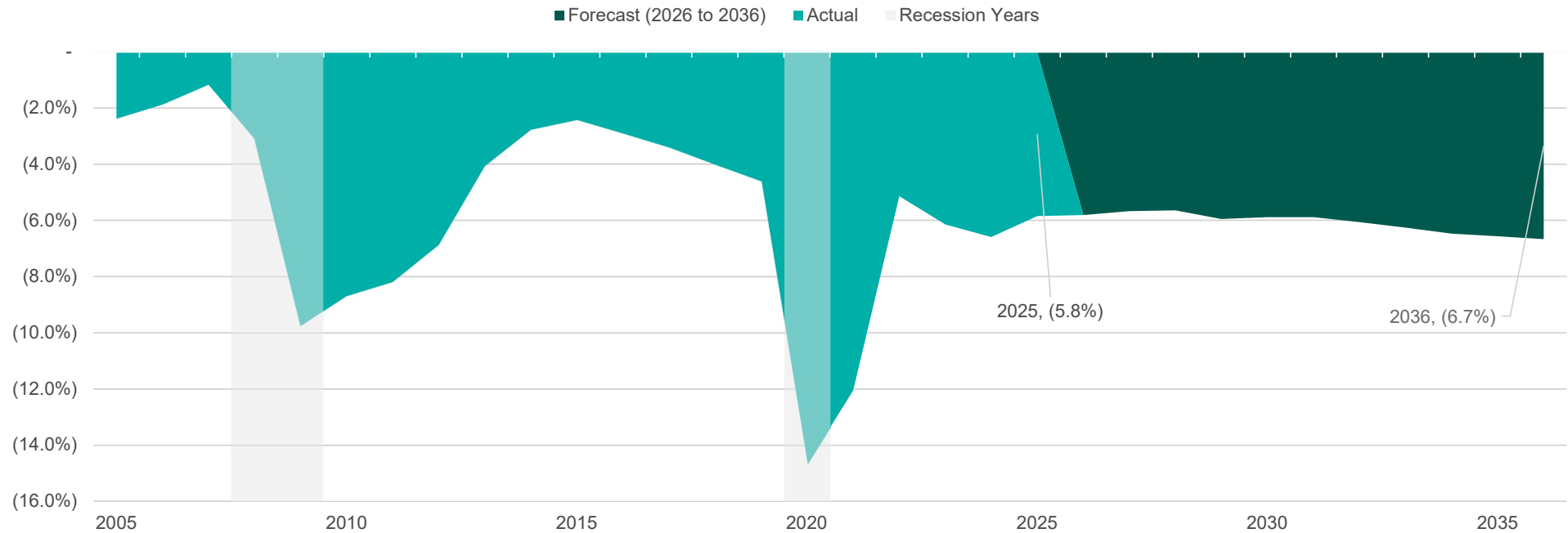
Economic Analysis

Strictly Private and Confidential

Economic Analysis

The federal budget deficit has long been an area of concern of lawmakers. According to estimates from the Congressional Budget Office ("CBO"), the deficit was approximately 5.85% of gross domestic product ("GDP") in 2025. Since the Great Depression, the federal deficit has exceeded 6.0% of GDP only during and shortly after World War II, after the 2008 financial crisis (2009 through 2012), and the early years of the coronavirus pandemic (2020 and 2021). The deficit is projected to decrease to 5.81% of GDP in 2026, and increase to 6.67% of GDP in 2036.

Total Deficits and/or Surpluses as a Percent of Gross Domestic Product



Notes and Sources

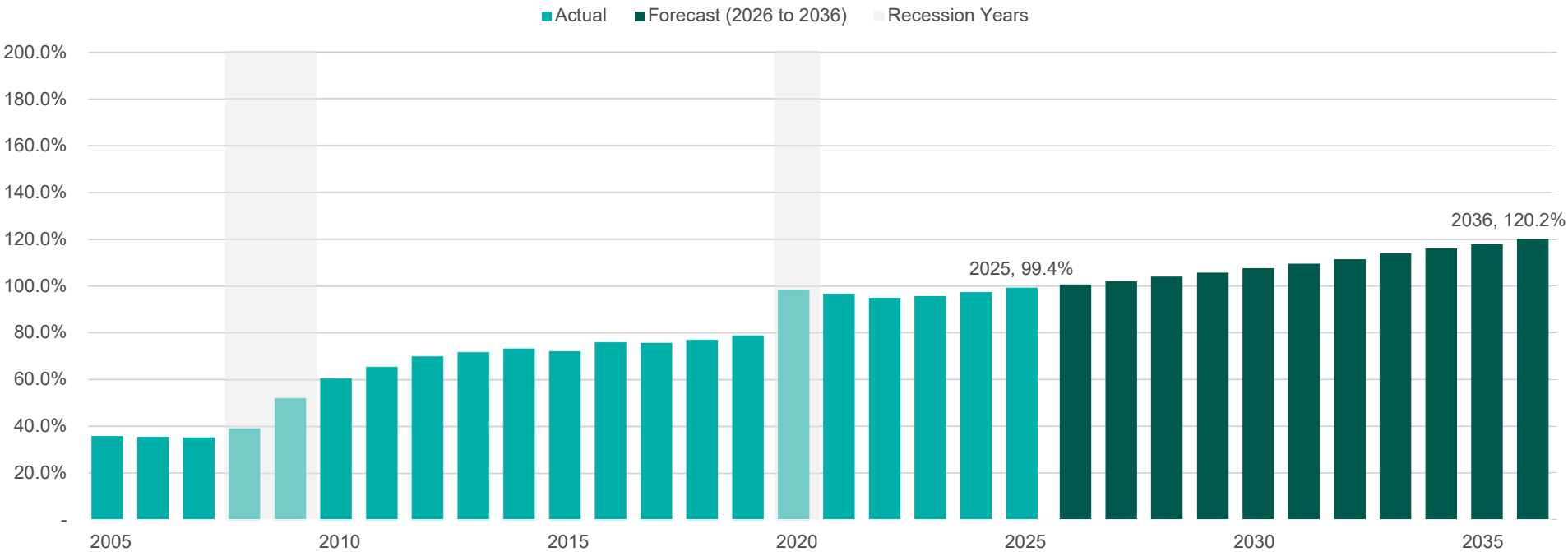
- (1) Source(s): Figure 1-1. Total Deficits, Net Outlays for Interest, and Primary Deficits. The Budget and Economic Outlook: 2026 to 2036, published February 11, 2026 by the Congressional Budget Office. <https://www.cbo.gov/system/files/2026-02/61882-Outlook-2026.pdf>
- (2) Source(s): Federal Reserve Bank of St. Louis, National Bureau of Economic Research ("NBER")-Based Recession Indicators for the United States from the Period following the Peak through the Trough ("USREC"). FRED, Federal Reserve Bank of St. Louis. Data retrieved December 4, 2025. <https://fred.stlouisfed.org/series/USREC>



Economic Analysis

According to estimates from the CBO, as a result of the aforementioned projected deficit, federal debt held by the public as a percent of GDP is projected to increase from 100.6% in 2026 to 120.2% in 2036, the highest level ever recorded.

Federal Debt Held by the Public as a Percent of Gross Domestic Product



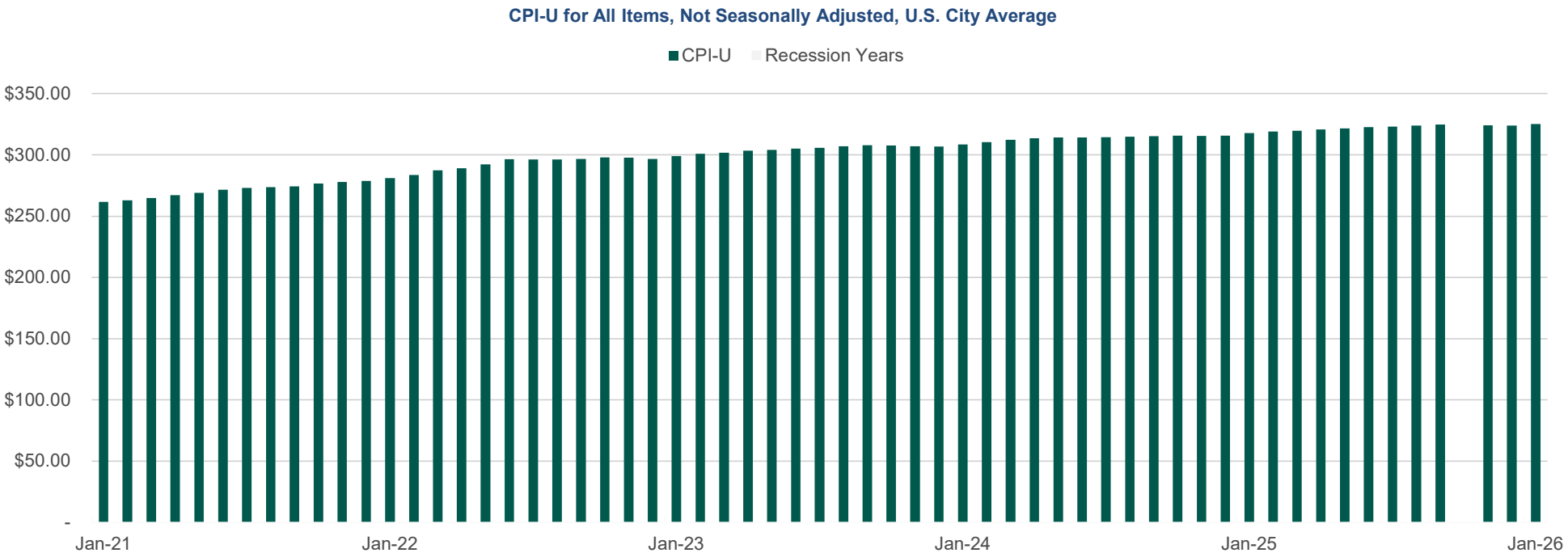
Notes and Sources

- (1) Source(s): Figure 1-8. Federal Debt Held by the Public, 1900 to 2056. The Budget and Economic Outlook: 2026 to 2036, published February 11, 2026 by the Congressional Budget Office. <https://www.cbo.gov/system/files/2026-02/61882-Outlook-2026.pdf>
- (2) Source(s): Federal Reserve Bank of St. Louis, National Bureau of Economic Research ("NBER")-Based Recession Indicators for the United States from the Period following the Peak through the Trough ("USREC"). FRED, Federal Reserve Bank of St. Louis. Data retrieved December 4, 2025. <https://fred.stlouisfed.org/series/USREC>



Economic Analysis

Presented in the chart below is the consumer price index for all urban consumers in the United States ("CPI-U"), not seasonally adjusted, from January 2021 to January 2026. The CPI-U measures the average change in price for a market basket of goods and services over time for urban consumers. The percentage change in the CPI-U is commonly used to measure the general inflation in the price of goods and services for urban consumers. According to the U.S. Bureau of Labor Statistics ("BLS"), from January 2021 to January 2026, CPI-U increased at a compound annual growth rate ("CAGR") of approximately 4.5%. More recently, CPI-U increased approximately 2.4% from January 2025 to January 2026.



Notes and Sources

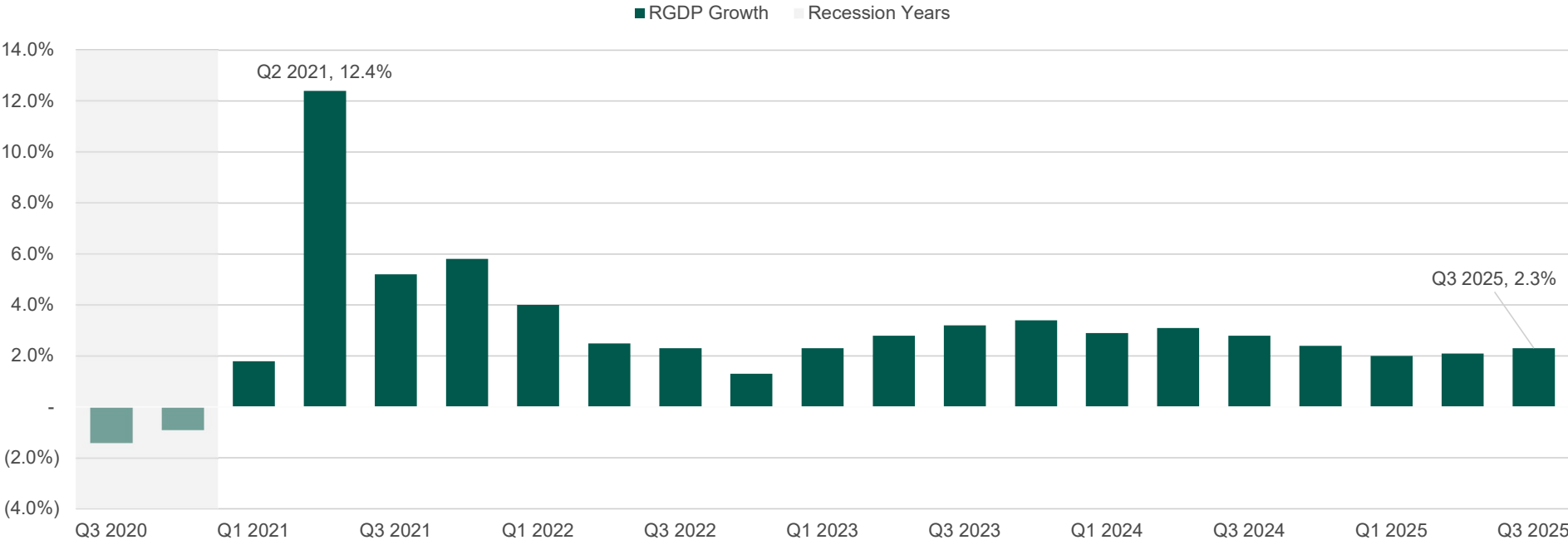
- (1) Source(s): Consumer Price Index for All Urban Consumers ("CPI-U"), Not Seasonally Adjusted. All Items, U.S. City Average. U.S. Bureau of Labor Statistics. Data retrieved February 15, 2026. <https://www.bls.gov/cpi/tables/supplemental-files/home.htm>
- (2) Source(s): Federal Reserve Bank of St. Louis, National Bureau of Economic Research ("NBER")-Based Recession Indicators for the United States from the Period following the Peak through the Trough ("USREC"). FRED, Federal Reserve Bank of St. Louis. Data retrieved December 4, 2025. <https://fred.stlouisfed.org/series/USREC>
- (3) October 2025 data values are not available due to the 2025 lapse in appropriations.



Economic Analysis

Gross domestic product ("GDP") is a measure of the value of the goods and services produced by the nation's economy less the value of the goods and services used up in production. GDP is also equal to the sum of personal consumption expenditures, gross private domestic investment, net exports of goods and services, and government consumption expenditures and gross investment. Real values are inflation-adjusted estimates (i.e., estimates that exclude the effects of price changes). According to the Bureau of Economic Analysis ("BEA"), annual real GDP growth over the last 5 years (Q3 2020 to Q3 2025), measured as the percent change from the quarter one year ago, has ranged from a low of (1.4%) in Q4 1982 to a high of 12.4% in Q2 2021. Most recently, Q3 2025 real GDP growth was reported to be 2.3% over Q3 2024, an increase from the previous quarter's (Q2 2025) real GDP growth of 2.1%.

Real Gross Domestic Product, Percent Change from Quarter One Year Ago, Quarterly, Seasonally Adjusted



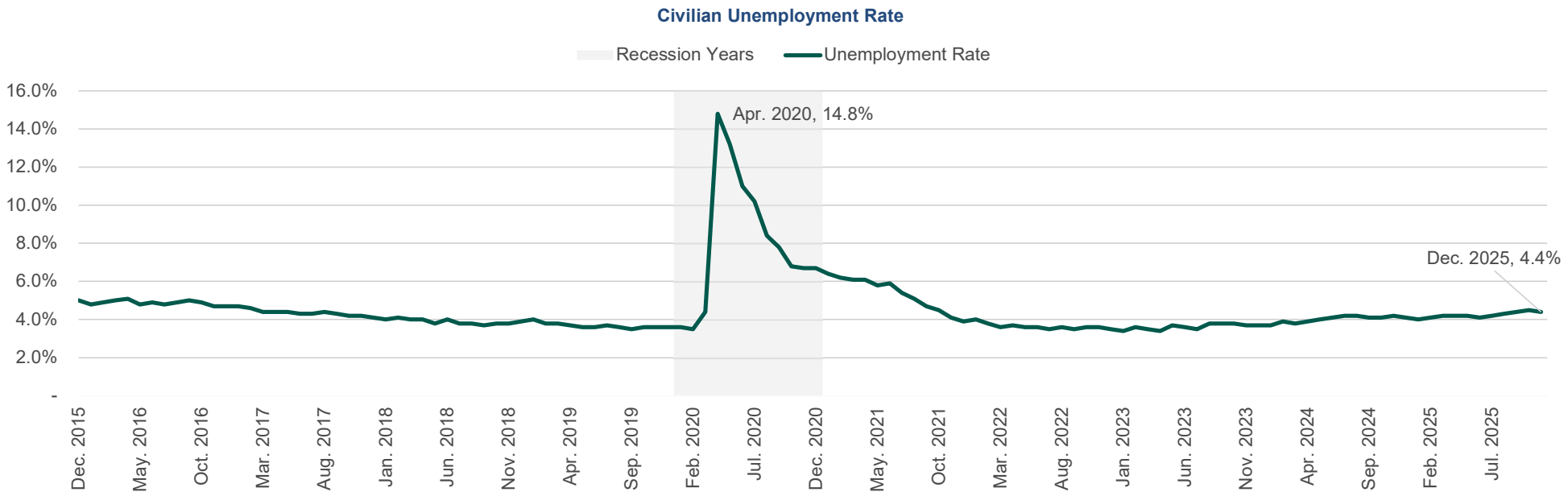
Notes and Sources

- (1) Source(s): U.S. Bureau of Economic Analysis, Real Gross Domestic Product, Federal Reserve Bank of St. Louis. Data retrieved January 13, 2026.
- (2) Source(s): Federal Reserve Bank of St. Louis, National Bureau of Economic Research ("NBER")-Based Recession Indicators for the United States from the Period following the Peak through the Trough ("USREC"). FRED, Federal Reserve Bank of St. Louis. Data retrieved December 4, 2025. <https://fred.stlouisfed.org/series/USREC>



Economic Analysis

The unemployment rate represents the number of unemployed people as a percentage of the labor force (the labor force is the sum of the employed and unemployed). According to the U.S. Bureau of Labor Statistics ("BLS"), the unemployment rate over the last 10 years (December 2015 to December 2025) has ranged from a low of 3.4% in January 2023 and April 2023 to a high of 14.8% in April 2020. Most recently, the unemployment rate was reported to be 4.4% as of December 2025, a decline from the previous month's unemployment rate of 4.5%.



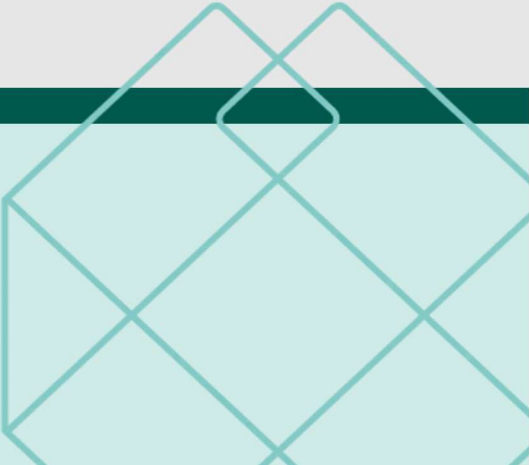
Notes and Sources

- (1) Source(s): Civilian Unemployment Rate, Seasonally Adjusted. U.S. Bureau of Labor Statistics. Data retrieved January 13, 2026. <https://www.bls.gov/charts/employment-situation/civilian-unemployment-rate.htm>
- (2) Source(s): Federal Reserve Bank of St. Louis, National Bureau of Economic Research ("NBER")-Based Recession Indicators for the United States from the Period following the Peak through the Trough ("USREC"). FRED, Federal Reserve Bank of St. Louis. Data retrieved December 4, 2025. <https://fred.stlouisfed.org/series/USREC>



Lower Keys Medical Center

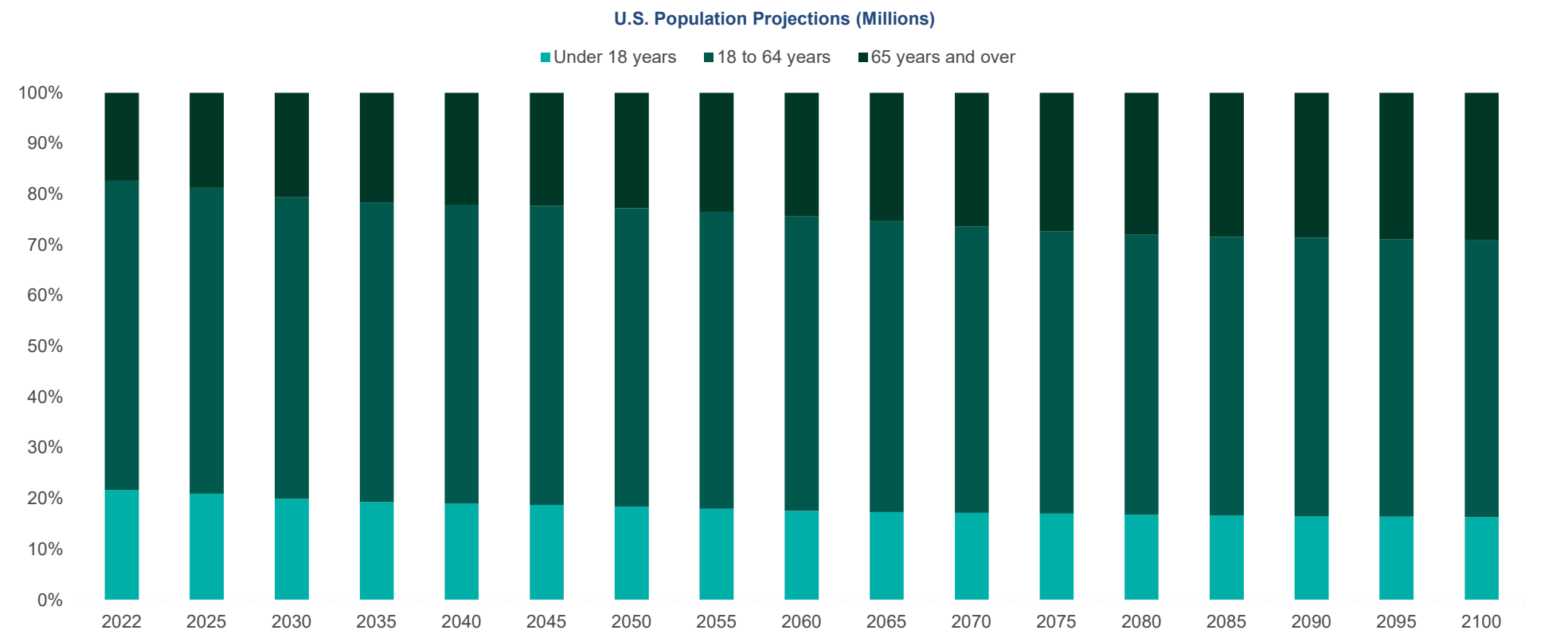
Demographic Anaylsis



Strictly Private and Confidential

Demographic Analysis

Presented in the chart below is a summary of the United States' historical and projected population by age category from 2022 to 2100 provided by the U.S. Census Bureau. As of 2022, there were approximately 57.8 million Americans (17.3% of the total population) 65 years of age or older. In addition, there are approximately 82.5 million Americans (24.8% of the total population) between the ages of 45 and 64 who will become eligible for Medicare over the next 15 to 20 years. Based on projections published by the U.S. Census Bureau, the total percentage of the United States' population over the age of 65 is projected to increase from 17.3% in 2022 to 29.1% in 2100. The aging of the United States' population is projected to drive increased demand for a variety of healthcare services. The projected increase in the number of Medicare beneficiaries and the historical increases in spending per beneficiary is a leading driver in how policy makers evaluate Medicare payments for healthcare services.



Notes and Sources

(1) Source(s): Table 2. Projected Population by Age Group and Sex for the United States, Main Series: 2022-2100. U.S. Census Bureau, Population Division. Released November 2023. <https://www.census.gov/data/tables/2023/demo/popproj/2023-summary-tables.html>



Demographic Analysis

The Hospital is located in Key West, Florida, which is located in Monroe County and, more broadly, the Key West-Key Largo, FL Micropolitan Statistical Area ("MSA"). Population estimates provided by the United States Census Bureau indicate the population of Monroe County decreased at a compound annual growth rate ("CAGR") of 0.6% from approximately 83,000 residents in 2020 to approximately 80,000 residents in 2025. Notably, the growth of the population of Monroe County was consistent with the CAGR for the broader Key West-Key Largo, FL MSA of 0.6%, and below the CAGR for the overall state of 1.7% over the same time period. Most recently, the population of Monroe County, Florida declined 2.0% from 2024 to 2025.

Population Estimates	2005	2010	2015	2020	2021	2022	2023	2024	2025
Monroe County, Florida	75,819	73,226	76,758	82,851	82,261	82,696	82,695	82,015	80,406
Year-Over-Year Growth		0.8%	0.5%	12.1%	(0.7%)	0.5%	(0.0%)	(0.8%)	(2.0%)
CAGR (Since 2005)		(0.7%)	0.1%	0.6%	0.5%	0.5%	0.5%	0.4%	0.3%
CAGR (Since 2015)				1.5%	1.2%	1.1%	0.9%	0.7%	0.5%
CAGR (Since 2020)					(0.7%)	(0.1%)	(0.1%)	(0.3%)	(0.6%)
Key West-Key Largo, FL	n/a	n/a	n/a	82,851	82,261	82,696	82,695	82,015	80,406
Year-Over-Year Growth		n/a	n/a	n/a	(0.7%)	0.5%	(0.0%)	(0.8%)	(2.0%)
CAGR (Since 2005)		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
CAGR (Since 2015)				n/a	n/a	n/a	n/a	n/a	n/a
CAGR (Since 2020)					(0.7%)	(0.1%)	(0.1%)	(0.3%)	(0.6%)
Florida	17,783,868	18,846,143	20,219,111	21,591,325	21,836,698	22,413,989	22,929,248	23,265,838	23,462,518
Year-Over-Year Growth		1.7%	1.8%	0.5%	1.1%	2.6%	2.3%	1.5%	0.8%
CAGR (Since 2005)		1.2%	1.3%	1.3%	1.3%	1.4%	1.4%	1.4%	1.4%
CAGR (Since 2015)				1.3%	1.3%	1.5%	1.6%	1.6%	1.5%
CAGR (Since 2020)					1.1%	1.9%	2.0%	1.9%	1.7%
United States	295,753,151	309,327,143	320,738,994	331,578,104	332,100,166	333,996,304	336,755,052	340,003,797	341,784,857
Year-Over-Year Growth		0.8%	0.7%	1.0%	0.2%	0.6%	0.8%	1.0%	0.5%
CAGR (Since 2005)		0.9%	0.8%	0.8%	0.7%	0.7%	0.7%	0.7%	0.7%
CAGR (Since 2015)				0.7%	0.6%	0.6%	0.6%	0.7%	0.6%
CAGR (Since 2020)					0.2%	0.4%	0.5%	0.6%	0.6%

Notes and Sources

(1) Source(s): United States Census Bureau

- Monroe County, Florida
 - 2000 – 2009: File Name: "co-est00int-tot.csv"; URL: <https://www2.census.gov/programs-surveys/popest/datasets/2000-2010/intercensal/county/>
 - 2010 – 2019: File Name: "co-est2020-alldata.csv"; URL: <https://www2.census.gov/programs-surveys/popest/datasets/2010-2020/counties/totals/>
 - 2020 – 2024: File Name: "co-est2025-alldata.csv"; URL: <https://www2.census.gov/programs-surveys/popest/datasets/2020-2025/counties/totals/>
- Key West-Key Largo, FL
 - 2000 – 2009: File Name: "cbsa-est2009-alldata.csv"; URL: <https://www2.census.gov/programs-surveys/popest/datasets/2000-2009/metro/totals/>
 - 2010 – 2019: File Name: "cbsa-est2020-alldata.csv"; URL: <https://www2.census.gov/programs-surveys/popest/datasets/2010-2020/metro/totals/>
 - 2020 – 2024: File Name: "cbsa-est2025-alldata.csv"; URL: <https://www2.census.gov/programs-surveys/popest/datasets/2020-2025/metro/totals/>
- Florida and United States
 - 2000 – 2009: File Name: "nst_est2009_alldata.csv"; URL: <https://www2.census.gov/programs-surveys/popest/datasets/2000-2009/national/totals/>
 - 2010 – 2019: File Name: "nst-est2020-alldata.csv"; URL: <https://www2.census.gov/programs-surveys/popest/datasets/2010-2020/state/totals/>
 - 2020 – 2025: File Name: "NST-EST2025-ALLDATA.csv"; URL: <https://www2.census.gov/programs-surveys/popest/datasets/2020-2025/state/totals/>



Demographic Analysis

Approximately 25.9% of the population of Monroe County, Florida is over the age of 65, higher than the United States population distribution for the same age category of approximately 18.3%, according to 2024 estimates. Notably, the 65+ population within Monroe County, Florida has increased at a compound annual growth rate ("CAGR") of approximately 2.6% from 2014 to 2024.

Population Distribution by Age	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Monroe County, Florida											
Population Distribution											
Age 19 and Under	16.7%	16.6%	16.6%	16.6%	16.8%	16.9%	17.1%	17.0%	17.0%	17.0%	17.1%
Age 20 to 34	17.9%	17.9%	18.0%	17.7%	17.2%	16.9%	16.1%	15.5%	15.4%	15.0%	14.8%
Age 35 to 64	45.3%	44.7%	44.1%	43.7%	43.4%	42.9%	43.1%	43.1%	43.1%	42.9%	42.2%
Age 65+	20.1%	20.7%	21.3%	22.0%	22.6%	23.3%	23.7%	24.3%	24.6%	25.2%	25.9%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Florida											
Population Distribution											
Age 19 and Under	22.8%	22.6%	22.5%	22.3%	22.2%	22.0%	22.1%	21.9%	21.8%	21.7%	21.6%
Age 20 to 34	19.4%	19.3%	19.3%	19.2%	19.1%	18.9%	18.6%	18.5%	18.5%	18.5%	18.5%
Age 35 to 64	38.9%	38.7%	38.6%	38.4%	38.3%	38.2%	38.5%	38.5%	38.4%	38.3%	38.2%
Age 65+	19.0%	19.4%	19.7%	20.1%	20.4%	20.9%	20.8%	21.2%	21.3%	21.5%	21.8%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
National											
Population Distribution											
Age 19 and Under	25.8%	25.6%	25.4%	25.3%	25.1%	24.9%	24.8%	24.5%	24.4%	24.2%	23.9%
Age 20 to 34	20.8%	20.8%	20.8%	20.7%	20.7%	20.6%	20.2%	20.1%	20.1%	20.1%	20.1%
Age 35 to 64	38.9%	38.7%	38.6%	38.4%	38.3%	38.1%	38.4%	38.3%	38.1%	37.9%	37.7%
Age 65+	14.5%	14.9%	15.2%	15.6%	16.0%	16.5%	16.7%	17.1%	17.5%	17.9%	18.3%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

2024 Monroe County, Florida Population Distribution



Notes and Sources

(1) Source(s): United States Census Bureau

- Monroe County, Florida, Florida, and National
 - 2000 – 2019: File Name: "CC-EST2020-ALLDATA6"; URL: <https://www2.census.gov/programs-surveys/popest/datasets/2010-2020/counties/asrh/>
 - 2020 – 2024: File Name: "cc-est2024-alldata.csv"; URL: <https://www.census.gov/data/datasets/time-series/demo/popest/2020s-counties-detail.html>

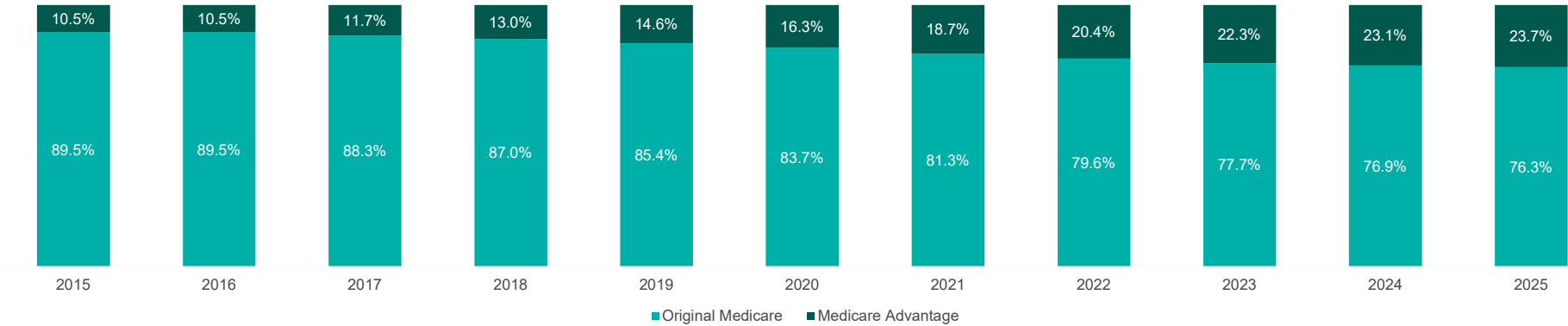


Demographic Analysis

As previously mentioned, the Hospital is located in Key West, Florida, which is located in Monroe County and, more broadly, the Key West-Key Largo, FL Micropolitan Statistical Area ("MSA"). Medicare enrollment estimates provided by the Centers for Medicare & Medicaid Services ("CMS") indicate Medicare enrollment in Monroe County increased at a compound annual growth rate ("CAGR") of 1.9% from approximately 16,000 enrollees in 2015 to approximately 19,000 enrollees in 2025. The change in Medicare enrollment has been driven by growth in Medicare Advantage. Notably, the growth of the Medicare population of Monroe County was below the CAGR for the overall state of 2.7% over the same time period. Most recently, Medicare enrollment within Monroe County grew 1.1% from 2024 to 2025. Medicare enrollment in Monroe County is most recently estimated to be approximately 19,000 as of October 2025.

Medicare Enrollment	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Monroe County, Florida											
Original Medicare	14,028	14,492	14,521	14,386	14,572	14,590	14,460	14,338	14,249	14,314	14,370
Medicare Advantage	1,639	1,697	1,925	2,153	2,483	2,850	3,316	3,681	4,082	4,304	4,459
Total Medicare Enrollment	15,667	16,189	16,446	16,539	17,055	17,440	17,776	18,019	18,331	18,618	18,829
Growth	n/a	3.3%	1.6%	0.6%	3.1%	2.3%	1.9%	1.4%	1.7%	1.6%	1.1%
Florida											
Original Medicare	2,429,260	2,466,747	2,467,994	2,459,533	2,455,760	2,411,819	2,359,847	2,320,310	2,281,358	2,252,528	2,270,248
Medicare Advantage	1,603,713	1,696,922	1,827,188	1,953,129	2,100,818	2,268,263	2,443,949	2,600,898	2,749,835	2,883,497	2,969,894
Total Medicare Enrollment	4,032,973	4,163,668	4,295,182	4,412,663	4,556,578	4,680,082	4,803,796	4,921,208	5,031,192	5,136,024	5,240,142
Growth	n/a	3.2%	3.2%	2.7%	3.3%	2.7%	2.6%	2.4%	2.2%	2.1%	2.0%
National											
Original Medicare	38,024,671	38,609,842	38,667,256	38,664,452	38,576,339	37,775,358	36,355,437	35,270,914	34,367,703	33,913,847	34,092,223
Medicare Advantage	17,470,948	18,370,800	19,789,413	21,324,800	22,937,498	25,063,922	27,536,246	29,829,632	32,142,166	34,081,269	35,344,370
Total Medicare Enrollment	55,495,618	56,980,641	58,456,670	59,989,252	61,513,836	62,839,280	63,891,683	65,100,546	66,509,869	67,995,116	69,436,593
Growth	n/a	2.7%	2.6%	2.6%	2.5%	2.2%	1.7%	1.9%	2.2%	2.2%	2.1%

Monroe County, Florida Total Medicare Enrollment from 2015 to 2025



Notes and Sources

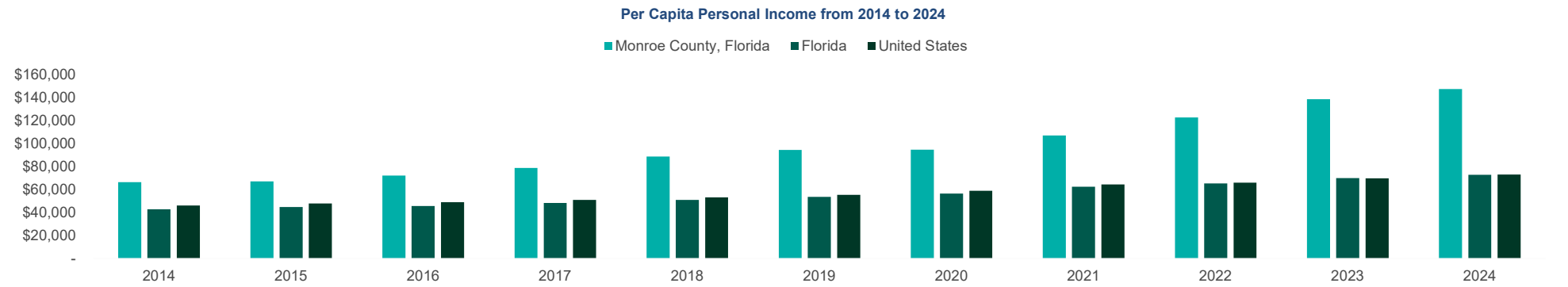
(1) Source(s): Medicare Monthly Enrollment data published by the Centers for Medicare & Medicaid Services. <https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicare-reports/medicare-monthly-enrollment>



Demographic Analysis

As previously mentioned, the Hospital is located in Key West, Florida, which is located in Monroe County and, more broadly, the Key West-Key Largo, FL Micropolitan Statistical Area ("MSA"). Per capita income estimates provided by the United States Bureau of Economic Analysis ("BEA") indicate per capita personal income in Monroe County increased at a compound annual growth rate ("CAGR") of 8.3% from approximately \$66,600 in 2014 to approximately \$147,800 in 2024. The BEA defines "Personal Income" as "Income that people get from wages, proprietor's income, dividends, interest, rents, and government benefits. A person's income is counted in the county, metropolitan statistical area, or other area where they live, even if they work elsewhere." As of 2024, Monroe County's reported per capita personal income of approximately \$147,800 was greater than the reported per capita personal income of the overall state of Florida of approximately \$73,000, and greater than the reported per capita personal income for the United States of approximately \$73,200.

per Capita Income Estimates	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Monroe County, Florida											
Population (Thousands)	80.1	81.4	82.5	83.0	81.7	82.2	82.9	82.2	82.0	81.3	80.9
Personal Income (Millions)	\$5,334	\$5,467	\$5,974	\$6,558	\$7,252	\$7,773	\$7,857	\$8,815	\$10,080	\$11,287	\$11,955
Per Capita Personal Income (Dollars)	\$66,557	\$67,131	\$72,370	\$78,983	\$88,735	\$94,612	\$94,832	\$107,197	\$122,924	\$138,825	\$147,760
Growth	n/a	0.9%	7.8%	9.1%	12.3%	6.6%	0.2%	13.0%	14.7%	12.9%	6.4%
Florida											
Population (Thousands)	19,790.1	20,140.4	20,533.5	20,868.3	21,131.2	21,353.3	21,592.0	21,831.9	22,379.3	22,904.9	23,372.2
Personal Income (Millions)	\$848,535	\$905,450	\$938,986	\$1,011,002	\$1,078,011	\$1,145,939	\$1,222,053	\$1,367,062	\$1,464,251	\$1,604,650	\$1,706,306
Per Capita Personal Income (Dollars)	\$42,877	\$44,957	\$45,730	\$48,447	\$51,015	\$53,666	\$56,597	\$62,617	\$65,429	\$70,057	\$73,006
Growth	n/a	4.9%	1.7%	5.9%	5.3%	5.2%	5.5%	10.6%	4.5%	7.1%	4.2%
United States											
Population (Thousands)	319,258	321,815	324,353	326,609	328,530	330,226	331,578	332,100	334,017	336,806	340,111
Personal Income (Millions)	\$14,778,160	\$15,467,113	\$15,884,741	\$16,658,962	\$17,514,402	\$18,349,584	\$19,613,059	\$21,484,168	\$22,144,814	\$23,577,208	\$24,897,613
Per Capita Personal Income (Dollars)	\$46,289	\$48,062	\$48,974	\$51,006	\$53,311	\$55,567	\$59,151	\$64,692	\$66,298	\$70,002	\$73,204
Growth	n/a	3.8%	1.9%	4.1%	4.5%	4.2%	6.4%	9.4%	2.5%	5.6%	4.6%



Notes and Sources

(1) Source(s): "Personal Income by County, Metro, and Other Areas." United States Bureau of Economic Analysis. Data retrieved February 15, 2026. <https://www.bea.gov/data/income-saving/personal-income-county-metro-and-other-areas>

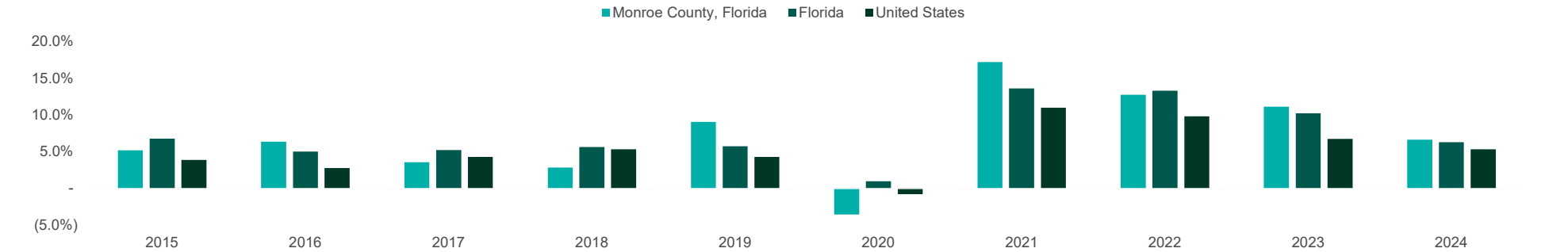


Demographic Analysis

As previously mentioned, the Hospital is located in Key West, Florida, which is located in Monroe County and, more broadly, the Key West-Key Largo, FL Micropolitan Statistical Area ("MSA"). Gross domestic product ("GDP") estimates provided by the United States Bureau of Economic Analysis ("BEA") indicate Monroe County's GDP (All Industry, Total) increased at a compound annual growth rate ("CAGR") of 7.0% from 2014 to 2024. The BEA defines "GDP" as "A comprehensive measure of the economies of counties, metropolitan statistical areas, and some other local areas. Gross domestic product estimates the value of the goods and services produced in an area. It can be used to compare the size and growth of county economies across the nation." From 2023 to 2024, Monroe County's reported GDP (All Industry, Total) growth of approximately 6.7% was greater than the reported GDP growth of the overall state of Florida of approximately 6.3%, and greater than the reported GDP growth for the United States of approximately 5.3%.

Gross Domestic Product Estimates (Millions)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Monroe County, Florida											
All Industry, Total	\$4,248	\$4,469	\$4,754	\$4,924	\$5,065	\$5,525	\$5,330	\$6,248	\$7,045	\$7,828	\$8,350
Growth	n/a	5.2%	6.4%	3.6%	2.9%	9.1%	(3.5%)	17.2%	12.8%	11.1%	6.7%
Health Care and Social Assistance	\$182	\$196	\$199	\$196	\$199	\$213	\$216	\$230	\$243	\$266	\$286
Growth	n/a	7.4%	2.0%	(1.8%)	1.6%	6.8%	1.4%	6.6%	5.7%	9.3%	7.8%
Florida											
All Industry, Total	\$860,113	\$918,464	\$964,501	\$1,014,867	\$1,072,086	\$1,133,718	\$1,144,653	\$1,300,808	\$1,473,688	\$1,624,642	\$1,726,710
Growth	n/a	6.8%	5.0%	5.2%	5.6%	5.7%	1.0%	13.6%	13.3%	10.2%	6.3%
Health Care and Social Assistance	\$72,346	\$77,229	\$81,394	\$85,125	\$88,931	\$94,022	\$93,928	\$103,238	\$113,424	\$126,615	\$136,474
Growth	n/a	6.7%	5.4%	4.6%	4.5%	5.7%	(0.1%)	9.9%	9.9%	11.6%	7.8%
United States											
All Industry, Total	\$17,608,138	\$18,295,019	\$18,804,913	\$19,612,102	\$20,656,516	\$21,539,982	\$21,375,281	\$23,725,645	\$26,054,614	\$27,811,517	\$29,298,013
Growth	n/a	3.9%	2.8%	4.3%	5.3%	4.3%	(0.8%)	11.0%	9.8%	6.7%	5.3%
Health Care and Social Assistance	\$1,270,169	\$1,343,568	\$1,413,751	\$1,471,334	\$1,534,734	\$1,613,933	\$1,615,102	\$1,734,179	\$1,863,046	\$2,043,659	\$2,209,381
Growth	n/a	5.8%	5.2%	4.1%	4.3%	5.2%	0.1%	7.4%	7.4%	9.7%	8.1%

Annual Percent Change in GDP Estimates (All Industry, Total)



Notes and Sources

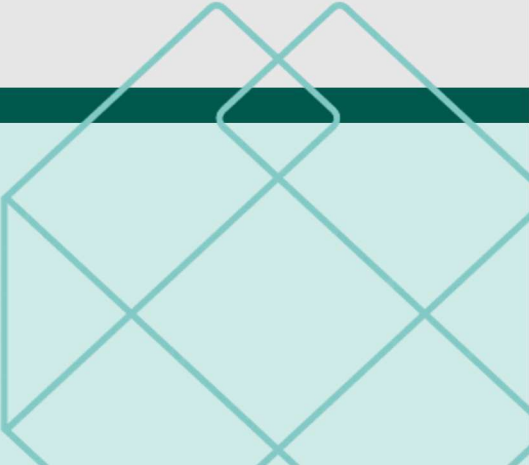
(1) Source(s): "GDP in Current Dollars by County and MSA." U.S. Bureau of Economic Analysis. Data retrieved February 15, 2026. <https://www.bea.gov/data/gdp/gdp-county-metro-and-other-areas>



Final Report

Lower Keys Medical Center

General Acute Care Hospital Industry Analysis



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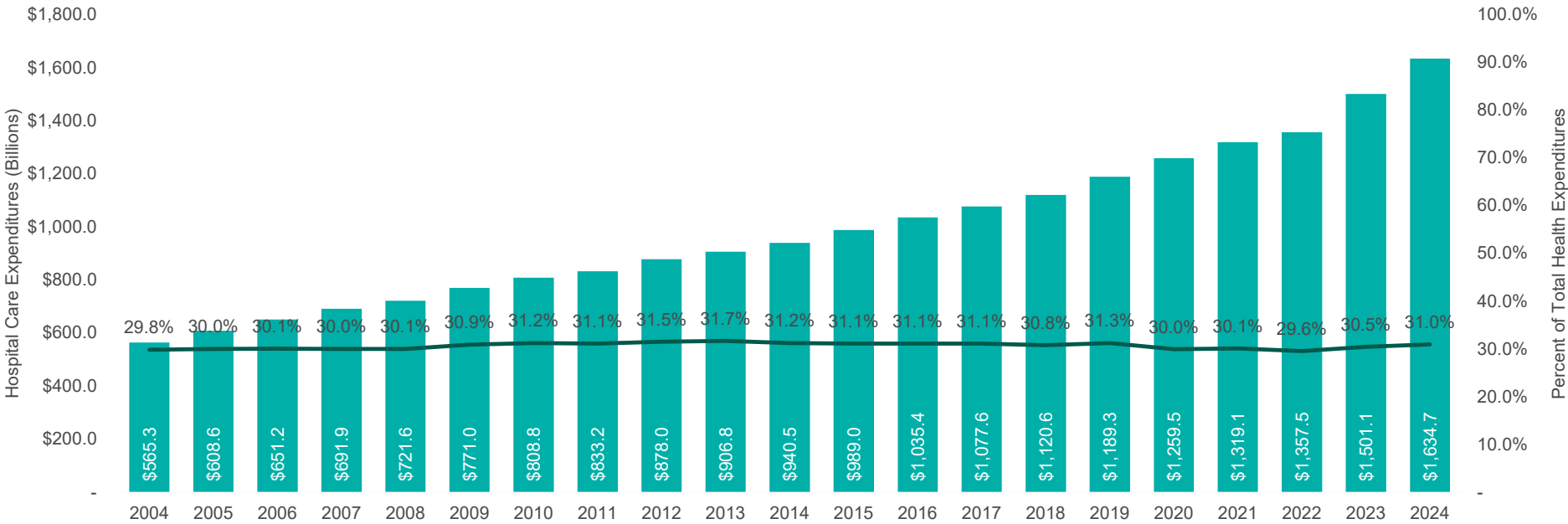
General Acute Care Hospital Industry Analysis

Analysis of Total Hospital Spending

The National Health Expenditure Accounts ("NHEA") are the official estimates of total health care spending in the United States reported by the Centers for Medicare & Medicaid Services ("CMS"). Dating back to 1960, the NHEA measures annual U.S. expenditures for health care goods and services, public health activities, government administration, the net cost of health insurance, and investment related to health care. The data is presented by type of service, including hospital care, which covers all services provided by hospitals to patients and has accounted for the largest percentage of total health expenditures compared to all other categories since 1960. Hospital care services include room and board, ancillary charges, services of resident physicians, inpatient pharmacy, hospital-based nursing home and home health care, and any other services billed by hospitals in the United States. The value of hospital services is measured by total net revenue, which equals gross patient revenues (charges) less contractual adjustments, bad debts, and charity care. It also includes government tax appropriations as well as non-patient and non-operating revenues.

According to the latest NHEA reports, total expenditures for hospital services were \$1,634.7 billion, or approximately 31.0% of total health expenditures during 2024. Total hospital spending has increased at a compound annual growth rate ("CAGR") of approximately 5.5% from \$565.3 billion in 2004 to \$1,634.7 billion in 2024. The growth in hospital spending has accounted for a significant portion of growth in total national healthcare expenditures in recent years, most recently increasing 8.9% from \$1,501.1 billion in 2023 to \$1,634.7 billion in 2024.

Expenditures from Hospital Care Services from 2004 through 2024



Notes and Sources

(1) Source(s): National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2024. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical>

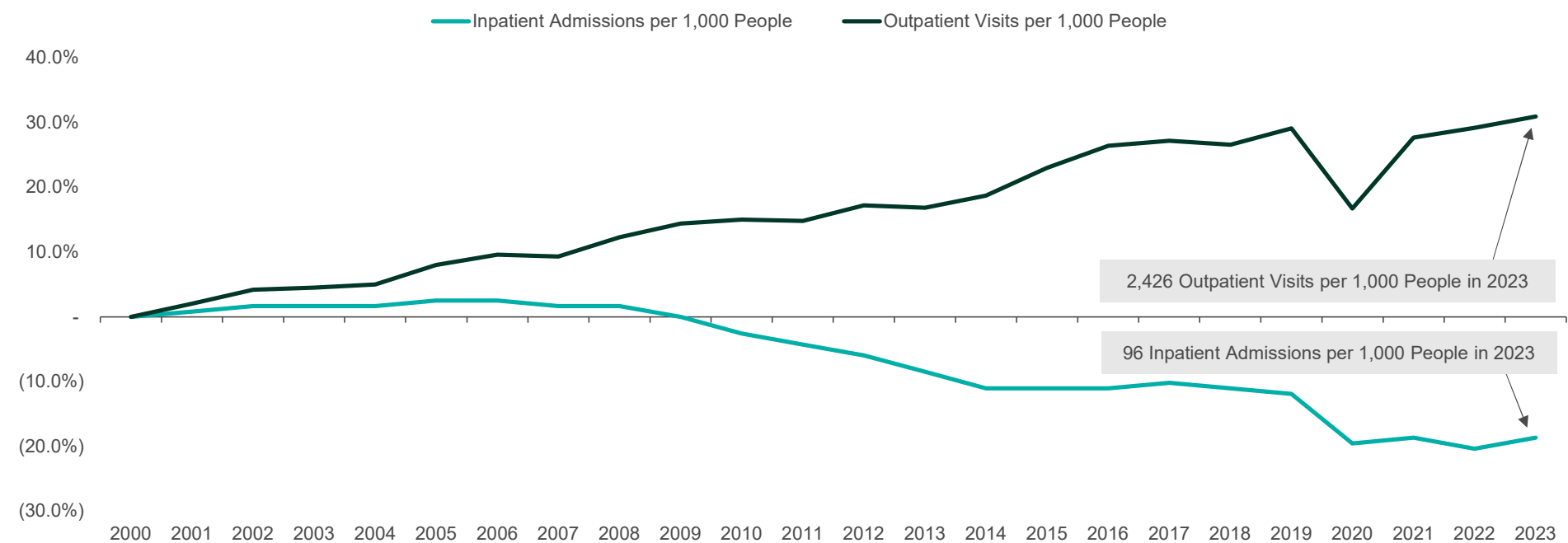


General Acute Care Hospital Industry Analysis

Analysis of Utilization Trends

As mentioned previously, acute care hospitals provide a variety of inpatient and outpatient services. Presented in the chart below is the cumulative growth in inpatient admissions and outpatient visits per 1,000 people from 2000 to 2023 based on an analysis of community hospitals (excluding hospitals in U.S. territories), published by KFF. From 2000 to 2023, the number of inpatient admissions per 1,000 people has decreased 18.6% cumulatively, while the total number of outpatient visits per 1,000 individuals has increased 30.9% cumulatively. These volume trends are the result of an increased migration of services from the inpatient setting to the outpatient setting due to technological advances and pressure from payors and patients to reduce costs.

Cumulative Growth per 1,000 People (2000 through 2023)



Notes and Sources

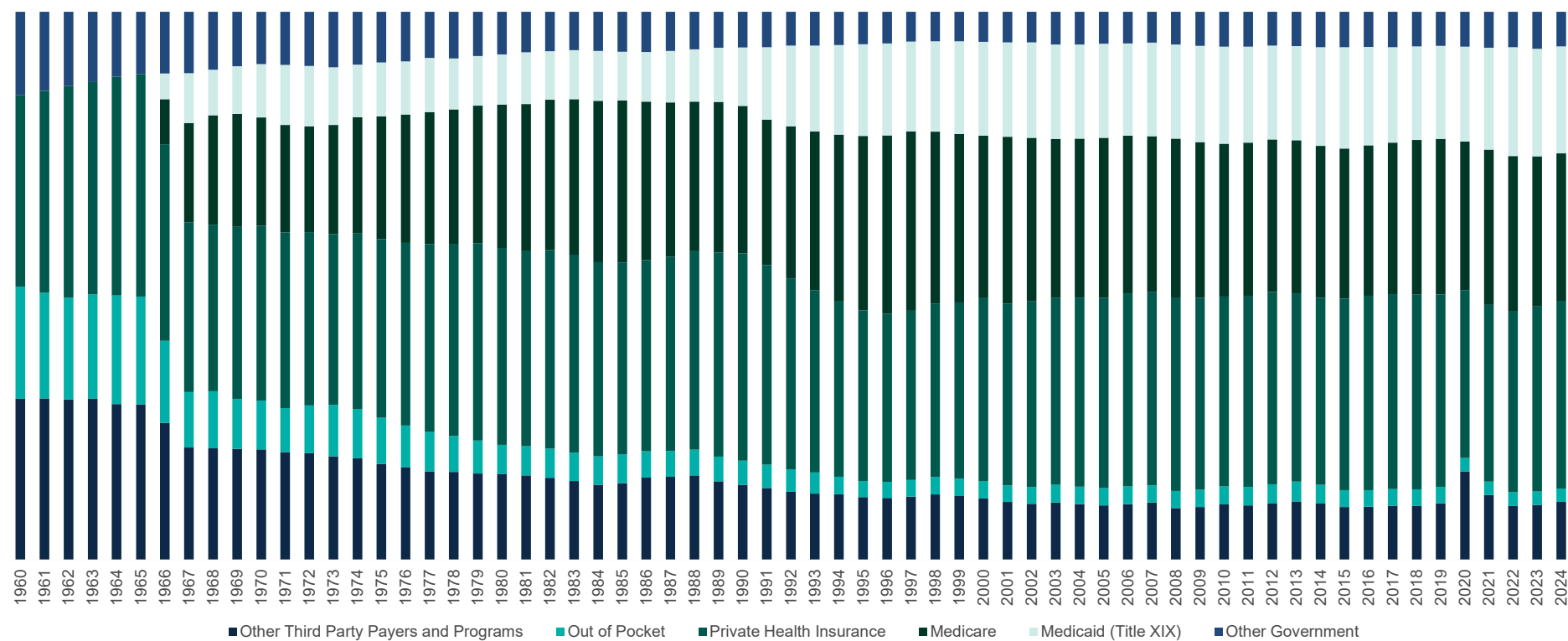
(1) Source(s): "Key Facts About Hospitals" by Zachary Levinson, Scott Hulver, Jamie Godwin, and Tricia Neuman. KFF, February 19, 2025. <https://www.kff.org/key-facts-about-hospitals/?entry=overview-introduction>



General Acute Care Hospital Industry Analysis

Analysis of Hospital Payor Mix

Presented in the chart below illustrates the relative allocation of total hospital spending by payor from 1960 to 2024 according to the latest NHEA reports published by CMS. In 2024, hospital spending was primarily from Private Health Insurance, which accounted for 34.2% of total hospital spending. Payment rates from private health insurers are negotiated with the individual payors and typically are paid a predetermined rate per diagnosis, per-diem, discount of charges, or other contractual arrangements. The next two largest payors in 2024 were Medicare and Medicaid (Title XIX), which accounted for 26.9% and 19.5% of total hospital spending, respectively.



Notes and Sources

(1) Source(s): National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2024. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical>



General Acute Care Hospital Industry Analysis

Healthcare Legislative Overview

The Patient Protection and Affordable Care Act (“PPACA”) and the Health Care and Education Reconciliation Act, signed into law on March 23, 2010, have significantly changed the way that healthcare services in the United States are covered, delivered, and reimbursed. The overall goal of this comprehensive legislation is to extend health coverage to millions of uninsured legal U.S. residents through a combination of private sector health insurance reforms and public program expansion. In order to fund the expansion of insurance coverage, PPACA contains measures designed to promote quality and cost efficiency in health care delivery in order to generate budgetary savings for the Medicare and Medicaid programs. The statutes and regulations of the PPACA have been the subject of various administrative appeals and lawsuits; however, some of the key provisions of the legislation include:

- **Individual Mandate:** The legislation originally contained an “Individual Mandate” which requires most Americans to maintain “minimum essential” health insurance coverage. Those that did not comply with the mandate were required to make a “shared responsibility payment” to the federal government in the form of a tax penalty. It should be noted that the Tax Cuts and Jobs Act passed by Congress in December 2017 eliminated the Individual Mandate penalty effective as of January 1, 2019.
- **Health Exchanges:** To assist individuals who are not exempt from the individual mandate and who do not receive health insurance through an employer or government program in obtaining insurance coverage, PPACA established health exchanges. Health exchanges are government regulated organizations which provide competitive markets for buying health insurance for individuals and small employers. Certain states have established their own health exchanges while other states have chosen to utilize the federal government’s health insurance exchange. Individuals who purchase a plan through the exchange may be eligible for a premium credit or cost sharing subsidy.
- **Employer Mandate:** The employer mandate provision of PPACA requires the imposition of penalties on employers with over 50 employees that do not offer affordable health insurance to employees working 30 or more hours per week. In February of 2014, the implementation of the employer mandate was delayed until January 1, 2016 for companies with 50 to 100 employees. For companies with more than 100 employees, the percentage of full-time workers required to be covered was reduced to 70.0% in 2014 and 2015. In 2016 and subsequent years, employers with over 100 employees must offer health coverage to 95.0% of employees. Affordable health insurance is defined as premiums of no more than 9.5% of an employee’s income and the employer must pay 60.0% of the actuarial value of a worker’s coverage. Companies that fail to comply with the employer mandate can face fines of up to \$2,000 for each employee not covered.
- **Medicaid Expansion:** The PPACA extended eligibility under Medicaid to almost all individuals under the age of 65 with incomes up to 138.0% of the Federal Poverty Limit (“FPL”) beginning in 2014. Under the PPACA, the federal government paid 100.0% of the cost of Medicaid expansion in 2014 through 2016. Federal funding was reduced to 90.0% over the course of a four year period from 2017 through 2020 and remains at 90.0% in 2021 onward. Historically, the income levels for Medicaid eligibility were determined by the state and were typically around 106.0% of the FPL. Initially, PPACA required all states to expand Medicaid coverage or face possible reductions in existing funding for the Medicaid programs. However, the constitutionality of this mandate was challenged in September of 2011 in the court case of the National Federation of Independent Businesses vs. Sebelius (Secretary of the Department of HHS). The Supreme Court ruled that Congress had no authority to require the states to expand their respective Medicaid programs. Congress may offer grants to the individual states for expanding Medicaid coverage but existing Medicaid funding cannot be threatened. As a result of the ruling, the individual states were given the choice to expand Medicaid coverage.



General Acute Care Hospital Industry Analysis

Healthcare Legislative Overview

PPACA also contains a number of provisions designed to improve the quality and efficiency of medical care provided to Medicare and Medicaid beneficiaries. These provisions include the prohibition of Medicare or Medicaid funds from paying for the treatment of Hospital-Acquired Conditions (“HACs”), reductions in reimbursement for hospitals with excessive readmissions, creation of the Medicare value-based purchasing program, and the creation of the Center for Medicare & Medicaid Innovation to further explore potential hospital payment bundles. PPACA also establishes a number of additional health insurance reforms including:

- Establishes a minimum medical loss ratio of 85.0% for large group plans and 80% for small group plans.
- Health insurers may not establish lifetime or annual limits on the dollar value of benefits.
- May not rescind coverage of any enrollee except in instances of fraud.
- Health insurers must reimburse hospitals for emergency services provided to enrollees without the need for prior authorization and without regard to whether or not there is an existing contract with the provider.
- Extends dependent coverage until the age of 26.



General Acute Care Hospital Industry Analysis

Healthcare Legislative Overview

The PPACA also contains a number of provisions designed to reduce Medicare and Medicaid program spending. These provisions include negative productivity adjustments to the annual inflation updates for the Medicare fee schedules and reductions to the Medicare and Medicaid Disproportionate Share Hospital Payments (“DSH”). Beginning in 2010, CMS has made negative productivity adjustments to the annual market basket updates for Medicare’s IPPS, OPPS, LTACH PPS, and IRF PPS fee schedules. Below is a summary of the proposed changes to the Medicare and Medicaid DSH programs:

- **Medicare DSH Payments:** In addition to payments made under the inpatient prospective payment system for services provided directly to beneficiaries, Medicare makes payments to hospitals which treat a disproportionately high share of low-income patients. Prior to October 31, 2013, Medicare DSH payments were made based on statistical information defined by CMS and calculated as a percentage add-on to the MS-DRG payments. The PPACA revised the DSH adjustment effective for discharges occurring on or after October 31, 2013. Under the revised methodology, hospitals will receive 25.0% of the amount they previously would have received under the pre-PPACA formula. This portion is referred to as the “Empirically Justified Payment”.

Hospitals that qualify for the Empirically Justified Payment are also eligible to receive additional payments for uncompensated care, referred to as the “UC DSH Payment”. The UC DSH payment comprises the remaining 75.0% of the total DSH payments that would have been paid under the historical formula. Each eligible hospital will receive a UC DSH payment based on its share of uninsured low income days (which is the sum of the Medicaid days and Medicare SSI days). The total UC DSH payments are calculated at 75.0% of DSH payments that would have been made under previous methodology and is reduced annually by the percentage change in uninsured individuals under the age of 65.

- **Medicaid DSH Payments:** CMS makes Medicaid DSH payments to states who then determine the methodology for distributing the payments to the individual hospitals. Federal law requires that state Medicaid programs make DSH payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. In the fiscal year 2016, Medicaid DSH payments totaled approximately \$19.1 billion. The PPACA called for reductions in Medicaid DSH payments beginning in 2014. However, the decision not to expand Medicaid coverage by certain states resulted in several delays in the Medicaid DSH cuts. The Bipartisan Budget Act of 2018 pushed back Medicaid DSH payment reductions to FY 2020, when Medicaid DSH payments were scheduled to be reduced by \$4.0 billion increasing to \$8.0 billion annually from FY 2020 to FY 2025. More recently, the Coronavirus Aid, Relief, and Economic Security Act (the “CARES Act”) eliminated the proposed \$4.0 billion in Medicaid DSH payment reductions in 2020. In addition, the CARES Act reduces the proposed DSH cuts in 2021 by an additional \$4.0 billion and the Consolidated Appropriations Act in 2021 delayed implementation of reductions until FY 2024 when reductions of \$8.0 billion will resume annually through FY 2027.

Notes and Sources

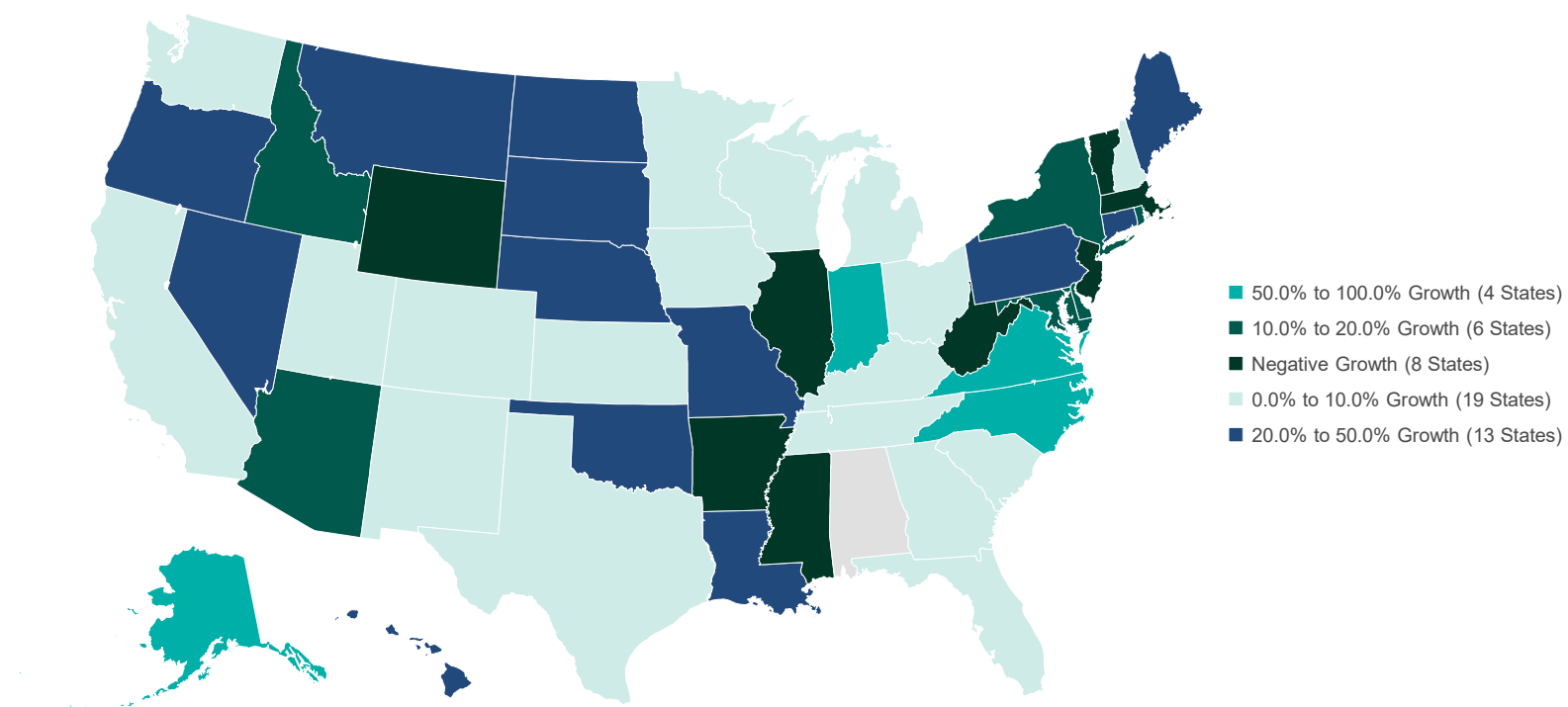
(1) Source(s): MedPAC and Medicaid & CHIP Payment and Access Commission



Medicaid Enrollment Trends by State

As previously mentioned, the PPACA required all states to expand Medicaid coverage or face possible reductions in existing funding for the Medicaid programs. However, the constitutionality of this mandate was challenged in September of 2011 in the court case of the National Federation of Independent Businesses vs. Sebelius (Secretary of the Department of HHS). The Supreme Court ruled that Congress had no authority to require the states to expand their respective Medicaid programs. Congress may offer grants to the individual states for expanding Medicaid coverage but existing Medicaid funding cannot be threatened. As a result of the ruling, the individual states were given the choice to expand Medicaid coverage. The chart below illustrates which states have elected to expand Medicaid and the resulting increase in enrollment from December 2014 to June 2025.

Medicaid Enrollment Growth from December 2014 to June 2025



Notes and Sources

- (1) Source(s): Medicaid Enrollment Data Collected through MBES. Accessed June 23, 2026. <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes>
- (2) Source(s): "Status of State Medicaid Expansion Decisions" KFF. May 21, 2026. <https://www.kff.org/status-of-state-medicaid-expansion-decisions/>



General Acute Care Hospital Industry Analysis

MedPAC Payment Basics: Overview of the Hospital Acute Inpatient Services Payment System

Acute care hospitals are paid under the inpatient prospective payment system ("IPPS"). The IPPS primarily pays prospectively determined rates per inpatient stay for hospitals' operating and capital costs. Certain costs are excluded from IPPS payments and paid separately, such as the direct costs of operating graduate medical education programs and organ acquisition costs. The fixed system of inpatient payment rates incentivizes providers to reduce their inpatient costs by moving some services to another setting.

Setting the Payment Rates

Medicare's IPPS payments per stay are derived through a series of adjustments applied to separate operating and capital base payment rates. The two base rates are adjusted to reflect geographic factors, patient case mix, facility characteristics, and other factors.

- **Base Payment Amounts** – Medicare sets operating and capital IPPS base rates, known as standardized payment amounts. Operating base payments are tied to labor and supply costs, and capital base payment amounts are tied to costs for depreciation, interest, rent, and property-related insurance and taxes.
- **Adjustment for Geographic Factors** – The operating and capital IPPS base rates are adjusted by a wage index to reflect the expected differences in local market prices for labor and labor-related costs. To determine the IPPS wage index for each hospital, CMS first calculates an unadjusted hospital wage index for each metropolitan statistical area and statewide rural area, which reflects the average hourly wage for employees of IPPS hospitals in that area relative to the nationwide average. CMS then applies several exceptions, including reclassifying some hospitals from one area to another and applying wage-index floors. For operating base rates, the wage index is applied to the portion of the base rate attributable to wages and wage-related costs. This operating labor share is set by statute at 62.0% for hospitals with a wage index less than or equal to 1 and is estimated by CMS for those with a wage index above 1. For capital base rates, the wage index raised to a fractional power is applied to 100.0% of the capital base rate.
- **Adjustment for Case Mix** – For each inpatient stay, the hospital's geographic-adjusted operating and capital rates are then adjusted for case mix to reflect the patient's condition and expected costliness. To determine this stay-level case-mix adjustment, Medicare assigns each inpatient stay to a Medicare severity diagnosis related group ("MS-DRG"), which is based on patient characteristics, primarily the patient's clinical conditions and treatment strategies. Clinical conditions are defined by the principal diagnosis—the main problem requiring inpatient care—and up to 24 secondary diagnoses indicating other conditions that were present at admission (comorbidities) or developed during the hospital stay (complications). The treatment strategy—surgical or medical—is defined by the presence or absence of up to 25 procedures performed during the stay. Each MS-DRG has a weight that reflects the expected costliness of inpatient treatment for patients in that group relative to the expected costliness across all patient groups.
- **Indirect Medical Education Payments** – Hospitals that train residents receive additional operating and capital IPPS payments to offset the additional (indirect) costs of patient care associated with resident training that are not otherwise accounted for under the IPPS. These indirect medical education ("IME") payments are calculated as a percentage add-on to geographic- and case-mix-adjusted base rates. The size of the IME percentage add-on depends on the hospital's teaching intensity, defined as the hospital's allowed number of residents per inpatient bed (for operating IME) or allowed residents per average daily inpatient census (for capital IME).



General Acute Care Hospital Industry Analysis

MedPAC Payment Basics: Overview of the Hospital Acute Inpatient Services Payment System

- Disproportionate Share and Uncompensated Care Payments** – Hospitals that treat a disproportionate share ("DSH") of certain low-income patients receive additional operating and capital payments intended to offset the financial effects of treating these patients. DSH payments are calculated as a percentage add-on to geographic– and case-mix–adjusted base rates. The size of the DSH percentage add-on depends on the hospital's low-income patient share, defined as the sum of the proportion of its Medicare inpatient days provided to patients eligible for Supplemental Security Income benefits and the proportion of its total acute inpatient days furnished to Medicaid patients. Any hospital with a low-income share exceeding 15.0% is eligible to receive operating DSH payments. To be eligible for capital DSH payments, hospitals must also be urban and have 100 or more beds. In addition, each DSH hospital receives uncompensated care payments from a fixed pool of dollars referred to as the "uncompensated care pool." The uncompensated care pool is allocated to DSH hospitals based on their share of reported uncompensated care costs in prior years relative to all other hospitals receiving DSH payments. Capital DSH payments are based on a prior-law DSH formula and do not include a component based on uncompensated care.
- Transfer Policy** – Facing fixed inpatient payment rates, providers have financial incentives to reduce their inpatient costs by moving some services to another setting. To counter these incentives, IPPS payments for a stay are reduced when patients have a length of stay at least one day less than the geometric mean length of stay for the MS–DRG and:
 - Are either transferred to another hospital covered by the IPPS or designated as a critical access hospital; or
 - For certain DRGs, discharged to a post-acute care setting.

Under this policy, transferring hospitals are paid a per diem rate rather than the full MS–DRG payment. Generally, hospitals receive twice the per diem rate for the first day and the per diem rate for each additional day.
- New-Technology Payments** – Hospitals with stays treated using certain new and expensive technologies receive add-on payments to offset the costs of these new technologies. CMS evaluates applications for new-technology add-on payments ("NTAP") submitted by technology firms and others based on criteria of newness, substantial clinical improvement, and the cost of the technology exceeding MS–DRG–specific thresholds. For stays involving eligible new technologies, NTAPs are generally set at 65.0% (or 75.0% for certain technologies) of the lesser of (1) the costs of the new technologies or (2) the amount by which the costs of the stay exceed the otherwise applicable IPPS operating payment (including IME and DSH).
- Outlier Payments** – Medicare makes extra payments for stays that are extraordinarily costly. High-cost outlier stays are identified by comparing the cost of that stay to a threshold that is the sum of the hospital's:
 - Geographic– and case-mix–adjusted base payment for the stay (both operating and capital);
 - Any IME, DSH, uncompensated care, and NTAP; and
 - A fixed loss amount (subject to geographic and transfer adjustments, as applicable).



General Acute Care Hospital Industry Analysis

MedPAC Payment Basics: Overview of the Hospital Acute Inpatient Services Payment System

For each stay that exceeds the threshold, Medicare makes an outlier payment equal to 80.0% of the hospital's costs above the threshold (or 90.0% for burn stays). Outlier payments are financed by prospective offsetting reductions in the operating base rate and the capital base rate. CMS sets the national fixed loss amount at the level it estimates will result in outlier payments equaling the target operating offset of 5.1% (plus a projection for outlier reconciliation, which is 0.04 percentage points in 2026).

- **Special Payments for Rural or Isolated Hospitals** – Medicare makes additional payments to certain rural or isolated hospitals.
 - **Sole Community Hospital Payments** – The sole-community hospital ("SCH") designation is for hospitals that are located at least 35 miles from the nearest short-term acute care hospital or are located in a rural area and meet criteria related to isolation. These hospitals receive inpatient operating payments equal to the higher of payments under the IPPS or payments based on their costs per stay in a base year updated to the current year and adjusted for their current year case mix.
 - **Medicare-Dependent Hospital Payments** – The Medicare-dependent hospital ("MDH") program is for small, rural hospitals not designated as SCHs in which Medicare patients comprise at least 60.0% of their admissions or patient days. These hospitals receive inpatient operating payments equal to the higher of standard IPPS rates or a blend of standard IPPS rates (25.0%) and their historical costs updated to the current year and adjusted for changes in their case mix (75.0%). The MDH program is scheduled to expire during fiscal year 2026.
 - **Low-Volume Hospital Payments** – The low volume hospital designation is for hospitals that have a low number of inpatient stays and meet criteria related to isolation. During fiscal year 2026, eligibility criteria is expected to narrow to hospitals with fewer than 200 total discharges during the fiscal year and that are located more than 25 miles from the nearest hospital (excluding critical access hospitals and Indian Health Service hospitals). These hospitals receive up to a 25.0% increase in their IPPS payments (including geographic- and case-mix-adjusted operating and capital base payments, and any IME, DSH, uncompensated care, new-technology, outlier, SCH, or MDH payments).

Quality Incentive Payments and Penalties

- **Excess Readmissions Penalty** – Under the Hospital Readmissions Reduction Program, hospitals that have excess Medicare readmissions for selected conditions have their adjusted operating base payments reduced by up to 3.0%. In fiscal year 2026, the readmissions policy applies to six conditions (acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, total hip and knee arthroplasty, and coronary artery bypass graft).
- **Value-Based Incentive Payments** – Under the value-based purchasing program, CMS redistributes a pool of dollars equal to 2.0% of adjusted operating base payments based on performance on a set of outcome, patient-experience, safety, and efficiency measures.
- **Hospital Acquired Conditions Penalty** – Under the Hospital-Acquired Condition Reduction Program, hospitals are ranked on their total rate of preventable conditions such as falls, surgical site infections, and catheter-associated urinary tract infections. The 25.0% of hospitals with the highest rates of preventable conditions generally receive a 1.0% reduction in all inpatient payments.



General Acute Care Hospital Industry Analysis

MedPAC Payment Basics: Overview of the Hospital Acute Inpatient Services Payment System

Payment Rate Updates

CMS makes several annual updates to IPPS payment rates, including updates to the base rates, wage indexes, MS–DRG definitions and weights, and the outlier fixed loss amount. IPPS base rates are updated annually primarily based on the operating and capital market basket indexes—which measure changes in the prices of the inputs hospitals buy—and estimated changes in productivity and other factors.

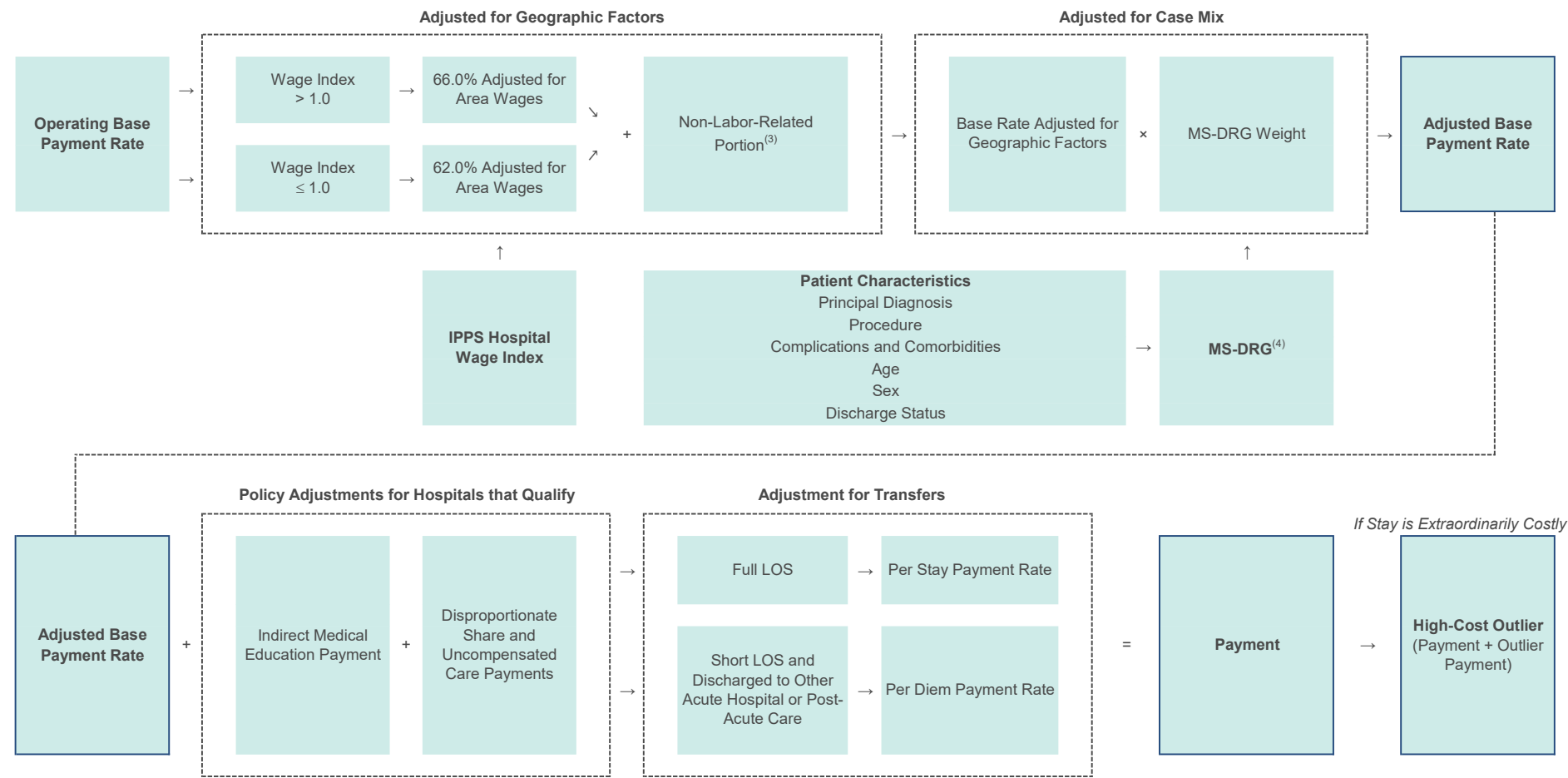
Notes and Sources

(1) "Hospital Acute Inpatient Services Payment System." *Payment Basics*. MedPAC. Revised November 2025. https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_hospital_FINAL_SEC.pdf



General Acute Care Hospital Industry Analysis

Figure 1. Acute Inpatient Operating Prospective Payment System for Fiscal Year 2026



Notes and Sources

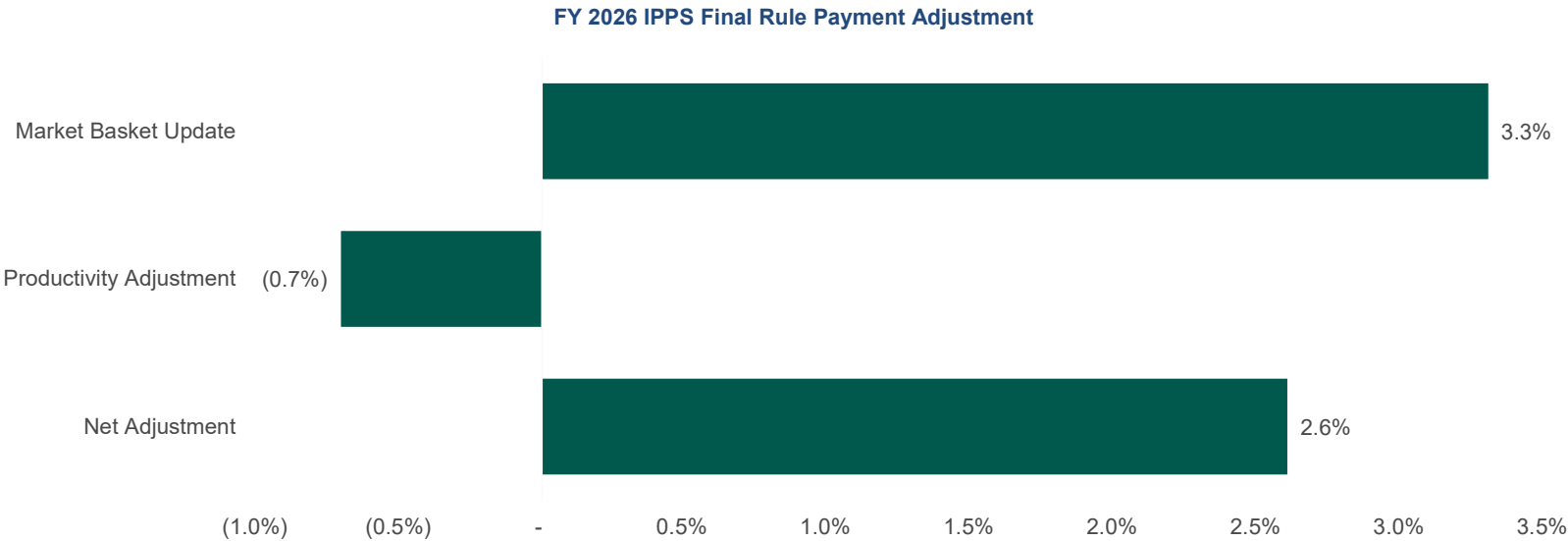
- (1) Source(s): "Hospital Acute Inpatient Services Payment System; Figure 1. Acute Inpatient Operating Prospective Payment System for Fiscal Year 2026." Payment Basics. MedPAC. Revised November 2025. https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_hospital_FINAL_SEC.pdf
- (2) MS-DRG = Medicare Severity Diagnosis Related Group; IPPS = Inpatient Prospective Payment System; LOS = Length of Stay. Capital payments are determined by a similar system. Additional payments are also made for certain new technologies and rural or isolated hospitals. Hospitals may receive penalties or additional payments based on their performance on quality standards.
- (3) Hospitals located in Alaska and Hawaii receive a cost-of-living adjustment to the non-labor-related portion of the base rate.
- (4) MS-DRGs comprise base DRGs subdivided into one, two, or three severity levels.



General Acute Care Hospital Industry Analysis

FY 2026 IPPS Final Rule Payment Adjustment

On July 31, 2025, the Centers for Medicare & Medicaid Services ("CMS") issued the final rule that updates Medicare payment policies and rates for inpatient and long-term care hospitals under the Medicare Hospital Inpatient Prospective Payment System ("IPPS") and Long-Term Care Hospital Prospective Payment System ("LTCH PPS") final rule for fiscal year ("FY") 2026. The increase in IPPS operating payment rates for general acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting ("IQR") program and are meaningful electronic health record ("EHR") users under the Medicare Promoting Interoperability Program is 2.6%. This reflects a projected FY 2026 hospital market basket percentage increase of 3.3%, reduced by a 0.7 percentage point productivity adjustment.



Notes and Sources

(1) Source(s): "FY 2026 Hospital Inpatient Prospective Payment System ("IPPS") and Long-Term Care Hospital Prospective Payment System ("LTCH PPS") Final Rule - CMS-1833-F." Centers for Medicare & Medicaid Services Fact Sheet. July 31, 2025. <https://www.cms.gov/newsroom/fact-sheets/fy-2026-hospital-inpatient-prospective-payment-system-ipp-and-long-term-care-hospital-prospective-0>



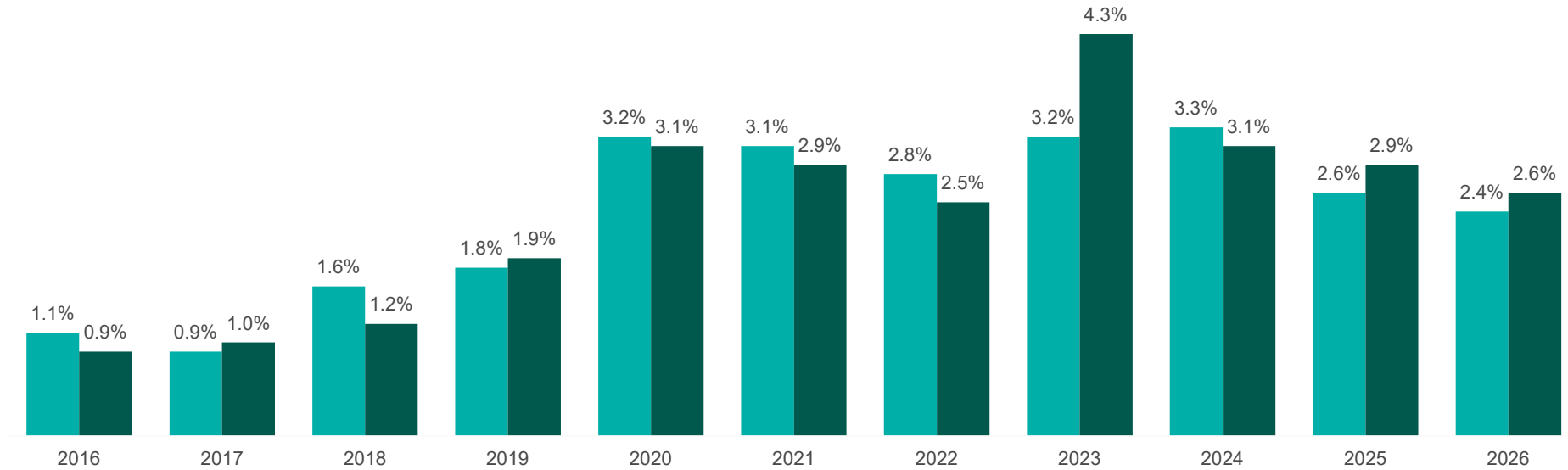
General Acute Care Hospital Industry Analysis

Historical IPPS Reimbursement

Presented in the chart below are the net proposed and final IPPS payment increases from 2016 through 2026. From 2005 through 2010, the average final rule payment increase averaged 3.3%, however, from 2010 through 2026, the final rule payment increase has averaged 2.4%. In more recent years, the relatively modest increases in the annual updates is primarily due to the productivity adjustment mandated by the PPACA and the documentation and coding adjustment mandated by the American Taxpayer Relief Act. It should be noted that payment increases presented below do not reflect any DSH or outlier payment adjustments.

Proposed and Final Rule for IPPS Payment Rate Changes by Fiscal Year

■ Proposed Rule ■ Final Rule



Notes and Sources

(1) Source(s): CMS Proposed and Final Rule Factsheets



General Acute Care Hospital Industry Analysis

MedPAC Payment Basics: Overview of the Outpatient Hospital Services Payment System

Defining the Outpatient Hospital Care that Medicare Buys

Medicare's payments under the OPSS cover the facility's portion of services provided in hospital outpatient departments ("HOPD"), including nursing services, medical supplies, equipment, and rooms. Under the OPSS, hospitals bill Medicare for services defined by Healthcare Common Procedure Coding System codes. CMS classifies groups of those service codes into ambulatory payment classifications ("APC") on the basis of clinical and cost similarity. All services within an APC have the same payment rate. In addition, each year CMS places new services to "new technology" APCs based only on similarity of resource use. Within each APC, CMS packages integral services and items with the primary service, so that hospitals receive a single fixed payment for all items and services in the package. In deciding which services to package, CMS considers comments from hospitals, hospital suppliers, and others. Currently, CMS pays separately for:

- Corneal tissue acquisition costs;
- Blood and blood products; and
- Drugs and biologicals whose costs exceed a threshold.

The intent of packaging is to give hospitals more incentive to consider the cost of the package of services used to treat a patient during an outpatient visit, and further evaluate treatment methods to identify lower-cost alternatives. Under the OPSS, a single, composite payment is made for certain combinations of services that would otherwise be paid under separate APCs when they are provided on the same date of service, as well as when two or more related ultrasound, MRI, or CT services are provided in the same outpatient visit. Comprehensive APCs ("C-APC") typically encompass larger payment bundles than do composite APCs. The idea is to provide single payments for entire outpatient encounters by combining a primary service and all other services provided during the same outpatient visit—including services that would otherwise be separately payable under the OPSS—into a single payment. However, some items and services, such as pass-through devices and drugs, are required by statute to be paid separately under the OPSS, and therefore are not part of C-APC payment bundles. While CMS makes most OPSS payments on a per service basis, CMS pays for partial hospitalizations on a per diem basis. The per diem rate represents the expected costs for a day of care in the facilities that provide these services.



General Acute Care Hospital Industry Analysis

MedPAC Payment Basics: Overview of the Outpatient Hospital Services Payment System

Setting the Payment Rates

CMS determines the payment rate for each service by multiplying the relative weight for the service's APC by a wage-adjusted conversion factor. The relative weight for an APC measures the resource requirements of the services and is based on the geometric mean cost of services in that APC. The conversion factor translates the relative weights into dollar payment rates. To account for geographic differences in input prices, CMS adjusts the labor portion of the conversion factor (60.0%) by the hospital wage index. CMS does not adjust the remaining 40.0%.

- Payments for New Technologies** – CMS assigns services to new-technology APCs on the basis of cost information collected from applications for new-technology status. CMS sets the payment rate for a new-technology APC at the midpoint of its cost range. Pass-through payments are used to pay for certain new drugs, biologics, and devices that providers use in the delivery of services. For pass-through devices, CMS bases payments on each hospital's costs, determined by charges adjusted to costs using a cost-to charge ratio. For pass-through drugs and biologics, CMS bases payments on average sales price ("ASP") plus 6.0%. Pass-through drugs, biologics, and devices can have pass-through status for two to three years. After that period, pass-through drugs and biologics are either packaged into the payment rate of the applicable service(s) or are granted separately payable status and continue to be paid at ASP plus 6.0%, while pass-through devices are packaged into the payment rate of the applicable service(s). Total pass-through payments cannot be more than 2.0% of total OPPS payments.
- Outlier Payments** – CMS makes an outlier payment when a hospital provides a service and incurs costs that are much higher than the payment rate for the service's APC. For 2025, CMS defines an outlier as a service with costs that exceed 1.75 times the APC payment rate and exceed the APC payment rate by at least \$7,175. For a service meeting both thresholds, CMS reimburses the hospital for 50.0% of the difference between the cost of furnishing the service and 1.75 times the APC rate. Outlier payments are financed by a prospective offsetting reduction to the conversion factor. For 2025, CMS limited aggregate outlier payments to 1.0% of total OPPS payments and accordingly reduced the conversion factor by 1.0%.

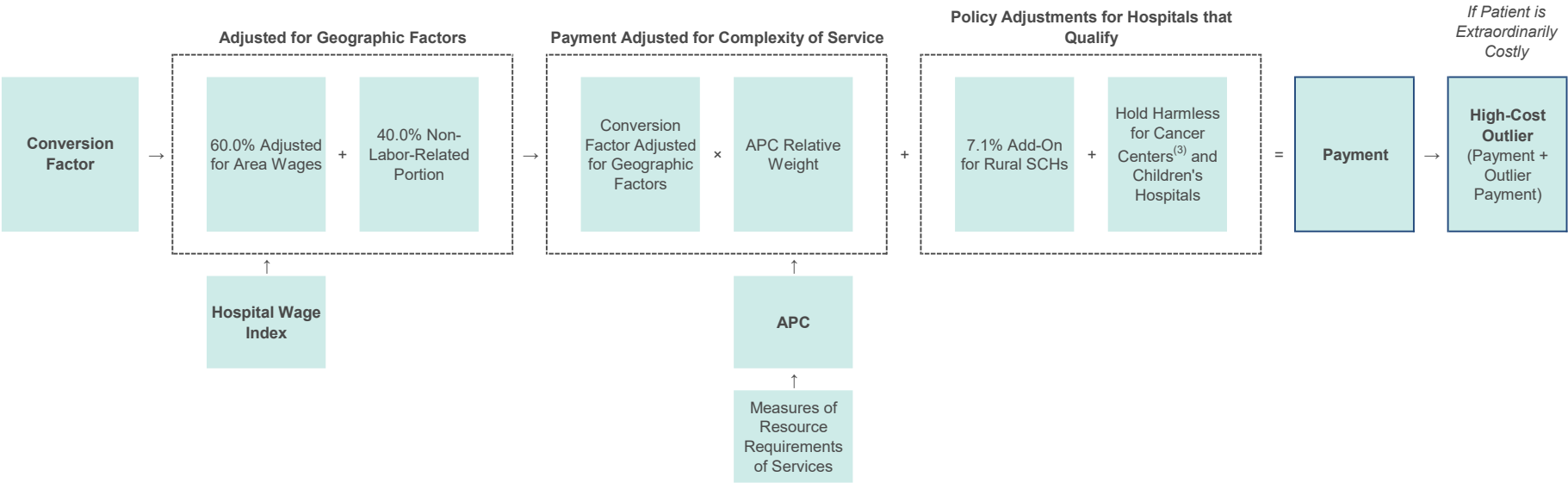
Notes and Sources

(1) Source(s): "Hospital Outpatient Services Prospective Payment System." *Payment Basics*, MedPAC. Revised November 2025. https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_OPD_FINAL_SEC.pdf



General Acute Care Hospital Industry Analysis

Figure 1. Hospital Outpatient Services Prospective Payment System, 2025



Notes and Sources

- (1) Source(s): Figure 1. Hospital Outpatient Services Prospective Payment System, 2025. Payment Basics, MedPAC. Revised November 2025. https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_OPD_FINAL_SEC.pdf
- (2) APC = Ambulatory Payment Classification; SCH = Sole Community Hospital. APCs are the service classification system for outpatient prospective payment system.
- (3) Medicare adjusts outpatient prospective payment system rates for 11 cancer centers so that the payment-to-cost ratio (PCR) for each cancer center is equal to the average PCR for all hospitals minus one percentage point.



General Acute Care Hospital Industry Analysis

CY 2026 Outpatient Prospective Payment System Final Rule

The CY 2026 Hospital Outpatient Prospective Payment System ("OPPS") Final Rule was released November 25, 2025. The CY 2026 conversion factor is \$91.4150 compared to the CY 2025 conversion factor of \$89.1690, reflecting an increase of approximately 2.5%. For the CY 2026 Final Rule, the OPD fee schedule increase factor for the CY 2026 OPPS is 2.6% (which reflects the 3.3% final estimate of the hospital inpatient market basket percentage increase with a negative 0.7 percentage point productivity adjustment). For CY 2026, CMS used a conversion factor of \$91.415 in the calculation of the national unadjusted payment rates for those items and services for which payment rates are calculated using geometric mean costs; that is, the OPD fee schedule increase factor of 2.6% for CY 2026, the required wage index budget neutrality adjustment of 0.9990, the 5.0% annual cap for individual hospital wage index reductions of 0.9995, the cancer hospital payment adjustment of 1.0000, and the adjustment of 0.07 (or 0.37 less 0.30) percentage point of projected OPPS spending for the difference in passthrough spending that results in a conversion factor for CY 2026 of \$91.415.

Table 8: Calculation of CY 2026 Final OPPS Conversion Factor	
CY 2025 Final OPPS Conversion Factor	\$89.1690
Adjustment for Additional Drug and Device Pass-Through and Outlier Spending	0.9863
Required Wage Index Budget Neutrality Adjustment	0.9990
Annual Cap for Individual Hospital Wage Index Reductions Adjustment	0.9995
Cancer Hospital Payment Adjustment	1.0000
Rural SCH Adjustment	1.0000
OPD Fee Schedule Increase	1.0260
Removal of Adjustment for Additional Drug and Device Pass-Through and Outlier Spending	0.9870
CY 2026 Final OPPS Conversion Factor	\$91.4150
Change from the CY 2025 Final OPPS Conversion Factor	2.5%

Notes and Sources

- (1) Source(s): "Hospital Outpatient Services Prospective Payment System." Payment Basics, MedPAC. Revised November 2025. https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_OPD_FINAL_SEC.pdf
- (2) "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Rating; Hospital Price Transparency; and Notice of Closure of a Teaching Hospital and Opportunity to Apply for Available Slots." Centers for Medicare & Medicaid Services (CMS); Department of Health and Human Services (HHS). Final Rule with Comment Period. November 25, 2025. Table 8: Calculation of CY 2026 Final OPPS Conversion Factor. Page(s) 46 and 47 of 641. <https://www.govinfo.gov/content/pkg/FR-2025-11-25/pdf/2025-20907.pdf>





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