The Florida Senate

Interim Project Summary 98-60 *October 1998*

Committee on Ways and Means Senator Donald C. Sullivan, Chairman

STUDY OF MEDICAL EDUCATION IN THE STATE OF FLORIDA

SUMMARY

This project was recommended during the 1998 legislative session because of managed care issues raised by the medical schools and the hospitals and because the State's role and financial commitment to fund the various aspects of medical education was unclear. In addition, there was considerable discussion related to expanding the FSU/UF Program in Medical Sciences(PIMS) from one to two years and also creating a medical school at Florida State University.

Two underlying concepts emerge as a result of the staff research. These are: 1) the financing of medical education is complex and 2)medical education is inextricably linked to the practice of medicine.

This is the result of multiple revenue streams, cross-subsidation of revenues and multiple activities associated with undergraduate medical education(4 years of medical school), graduate medical education(typically 3-5 years of residency specialty training), and research, which occur in numerous physical locations including the medical school sites, clinical sites, and hospitals.

Undergraduate medical education is primarily the responsibility of the medical schools although medical students learn how to provide patient care by observing and assisting medical faculty as they treat patients in the clinics or the hospitals. The colleges of medicine support graduate medical education through the allocation of faculty effort to the training and supervision of medical residents, however the primary funding source is through Medicare and Medicaid payments made directly to the hospitals. The number and type of residencies are determined by the hospitals, rather than the medical schools, the Board of Regents or the Legislature for community hospitals and jointly by the medical dean and the hospital for academic health centers. These residencies are approved by the Residency Review Committee similar to the accreditation review process used for State University System academic programs.

The Florida Legislature has a limited role in funding decisions related to undergraduate and graduate medical education and research. Subcommittee "C", of the Senate Ways and Means Committee, is involved to the extent that it addresses: 1) the graduate medical education component of the State's disproportionate share program-$19.4 million in 1997-98, 2) the Community Hospital Education Program-$6.8 million in 1997-98, 3) the Shands and Moffitt Cancer Center hospital contracts - $20.2 million in 1997-98 , and 4) funding for the diabetes centers-$1.0 million for 1997-98.

Subcommittee B, of the Senate Ways and Means Committee, also has limited involvement. In 1995-96, as shown on Table I, 89% of the college of medicine budget at the University of Florida and 83.7% of the University of South Florida medical budget was from non-appropriated revenue sources.

The primary revenue source for the allopathic colleges of medicine is from physician's fees which are billed and collected by entities managed by the colleges of medicine; the entities are referred to as faculty practice plans. Such large dependence on the faculty practice plans makes the medical schools susceptible to: 1)changes in health care delivery caused by managed care, 2)legislative reductions in the number of medicaid-eligible individuals, and 3)congressional proposals to change Medicare Part B physician's reimbursement policies.

Federal funding policies that are causing a negative impact on the revenue streams of the colleges of medicine and hospitals include:

1) a 4-year phase-in; beginning January 1, 1999, of a new formula for Medicare Part B physician's reimbursements which provide increases for primary care physicians and reductions for other specialties
2) formula changes in Direct Medical Education(DME) and Indirect Medical Education

(IME) payments, including a freeze at the 1996 level on the number of full-time-equivalent residents.
3) reductions in the IME payment from 7.7% to 5.5% by 2001.
4) a phased reduction in disproportionate care(DSH) payments beginning in 1998 at 1% and reaching 5% by year 2002.

This study:

- Defines Undergraduate and Graduate Medical Education.
- Describes the Medical Education process.
- Illustrates the UF and USF Colleges of Medicine revenue streams and program activities.
- Describes the changes in Federal funding policies which impact the colleges of medicine and the hospitals as a result of health care reform.
- Illustrates the State's involvement in the funding of undergraduate and graduate medical education.
- Describes Federal activities which may impact Graduate Medical Education.
- Identifies additional work that needs to be done in order to more fully assess the current and the future funding situation.
- Does not include an analysis of the FSU/Board of Regents independent study of undergraduate and graduate medical education which is due January 1, 1999.

The major recommendation includes:

- A task force should be convened subsequent to the 1999 Legislative Session for the purpose of assessing the impact of current Federal and State studies, new or emerging Federal policies, as well as addressing the need to develop more current and complete cost information.

BACKGROUND

For the past five years the deans of the State's four medical schools have participated in a multi-year, collaborative effort to increase the number of generalist physicians and to develop and implement proposals designed to mitigate the potentially adverse fiscal impact of health care reform and managed care funding policies on the teaching, research and clinical or patient care activities of the institutions. These medical schools consist of two public allopathic medical schools(University of Florida and University of South Florida), one private allopathic medical school(University of Miami), and one private osteopathic medical school (Nova/Southeastern).

Section 240.2995, Florida Statutes, was created by the 1995 Legislature authorizing state universities to establish Health Services Support Organizations for the purpose of entering into arrangements with providers for health partnerships or other integrated health care systems. University Health Services Support Organizations are authorized to become licensed as insurance companies, pursuant to chapter 624, Florida Statutes, or certified as health maintenance organizations, pursuant to chapter 641, F.S. The University of South Florida and the University of Florida have each established a University Health Services Support Organization. Neither university has chosen to become certified as a health maintenance organization, however, each university has entered into affiliation agreements with other health care providers.

Appropriations decisions by the Legislature have also supported funding for the medical schools to implement several initiatives to increase the number of medical students selecting careers in primary care and to promote interdisciplinary health care team training as follows: 1) modification of the undergraduate medical curriculum to emphasize primary care skills, 2) increasing the number of generalist physicians serving as medical faculty and community-based preceptors; and 3) expansion of the community-based clinical training sites in which generalist physicians and other health professionals are trained. Legislative Budgets submitted by the Board of Regents, for the two public and two private schools, included Managed Care requests totaling $14,242,500 for 1997-98 and $12,089,900 for 1998-99. In response, the Legislature appropriated funds totaling $3,100,000 for 1997-98 and $5,685,889 for the 1998-99 fiscal year.

The 1998 Legislature provided $950,000 to Florida State University for expansion of the Program in Medical Sciences(PIMS) from a one year program, concentrating on basic medical science, to a two year program that would include clinical training. PIMS is a University of Florida College of Medicine program at Florida State University which started in 1971 in response to the Surgeon General's report of a physician shortage. Through PIMS, students complete the first year of medical school at Florida State, primarily consisting of basic science courses, then they transfer to the University of Florida College of Medicine for

completion of the second through fourth year of undergraduate medical education. Federal matching funds allowing for geographically separated medical campuses, including PIMS, and construction of about twenty new medical schools nationwide, helped eliminate the perceived physician shortage; by the 1980's there was evidence of a physician surplus.

For the 1998 Legislative Session, a bill proposed in the House of Representatives would have established a medical school at Florida State University. Considerable debate occurred both over the expansion of the PIMS program to the second year and the establishment of the medical school at Florida State. An agreement signed by Chancellor Herbert and President D'Alemberte on May 1, 1998 specified that an independent study would be conducted for the purpose of assessing "the current adequacy and capacity of the State's undergraduate and graduate medical education and training programs" with "specific consideration of the adequacy of opportunities for under-represented populations and the supply of geriatricians and primary care physicians who understand the unique medical needs of Florida's elders. The study would include but not be limited to:

a. Recommended strategies to ensure access to medical education by under-represented populations including those from under-served rural and urban areas;
b. Recommended strategies to increase the production of primary care physicians who understand the unique medical needs of Florida's elders;
c. A specific study of the fiscal, programmatic, accreditation and policy implications of adding a second year to the Program in Medical Sciences (PIMS) at Florida State University and other medical education programs as may be identified as needed at other state universities;
d. Issues that may be raised by the Liaison Committee on Medical Education(LCME) and reommendations to resolve such issues. Representatives of the Liaison Committee on Medical Education shall be invited to Florida to identify any areas of concern related to medical education accreditation in order to clarify and reach agreement regarding action necessary to address LCME concerns; and
e. Recommended strategies, an implementation plan, and a timeline to achieve the objectives of the study and an estimate of the fiscal and programmatic considerations associated with each recommendation."

The study is to be considered by the Board of Regents in the development of its 5-year Master Plan and shall be submitted to the Governor, President of the Senate, and Speaker of the House of Representatives by January 1, 1999.

For Fiscal Year 1998-99, the Legislature increased the Graduate Medical Education component of the Medicaid Disproportionate Share Program. A total of $10.3 million was provided($4.5 million from State General Revenue and $5.8 million from federal funds.)

METHODOLOGY

The original workplan included the following: "monitor the Board of Regents independent study of the current adequacy and capacity of the State's undergraduate and graduate medical education training programs, analyze funding which is provided through Subcommittees B & C, identify funding which is not appropriated by the Legislature which is used by the universities to support medical education and patient care, and identify appropriate policies to be addressed."

Dr. Richard Janeway has been hired by Florida State University to conduct the medical education study. Preliminary interviews and an assessment of the issues to be addressed have been completed. An independent consulting firm will be hired to gather the appropriate data. It is anticipated that this process will be completed by the end of November culminating in a report by the January 1, 1999 deadline. Staff will monitor this work.

Funding which has been appropriated as a part of the State University System budget and the Agency for Health Care budget, as well as non-appropriated funding, has been identified. An interview has been held with the Vice Chancellor for Health Affairs and appropriate staff.

The Board of Regents' October, 1997 report entitled: "The Impact of Health Care Reform and Managed Care on Medical Education and Research in Florida" and other selected research papers served as a basis for the research. The Board of Regents will be updating their study in December, 1998. Historical differences in funding for osteopathic medical education result in skewed cost comparisons,therefore, issues related to the College of Osteopathic Medicine at Nova/Southeastern

have not been addressed although the college is affected by many of the same funding pressures.

This report summarizes the information that has been gathered to this point, identifies the issues and provides timeframes for addressing the issues.

FINDINGS

There are two primary concepts which emerge. These are: 1) The financing of medical education is complex, 2) Medical education is inextricably linked to the practice of medicine. These concepts drive the need for the medical schools and teaching hospitals to develop close relationships to achieve their multiple missions. It is these relationships, as they relate to undergraduate and graduate medical education and research, which staff attempted to document.

Medical education consists of two distinct phases: The first phase, referred to as Undergraduate Medical Education. begins with four years of medical school and ends with the awarding of the M.D. degree or D.O. degree for an osteopathic physician. The first year of medical school is primarily composed of lectures and labs in basic sciences taught by non-physician faculty. Beginning the second year the number of laboratory courses increases. These courses are taught by physician faculty. During year two, student contact with patients increases and continues to rise in years three and four which are almost exclusively clinical. During clinical rotations, medical students are closely supervised by physician faculty and medical residents.

The second phase begins upon completion of medical school when allopathic and osteopathic physicians enter residency training; this is referred to as Graduate Medical Education. Graduate medical education is comprised of multi-year residency programs which occur in hospitals and other clinical sites. These residencies typically range from three to five years in length, in one of approximately thirty-five specialties and fifty subspecialties of medicine such as family practice, internal medicine, vascular surgery, pediatric oncology for example. Physicians wishing to develop expertise beyond the standard residency training period do so in one to two year fellowships. For, example Geriatrics training which is one of the specialty areas to be addressed in the Florida State/Board of Regents study of medical education, is a fellowship after completion of a residency in family practice, internal medicine or psychiatry.

In order to practice medicine in Florida, a physician must be licensed by the Florida Board of Medicine or the Florida Board of Osteopathic Medicine. Licensure requires the following on the part of the allopathic physician: 1) graduation from an LCME accredited U.S. medical college or comparable international institution, 2) receipt of the M.D. degree or one of comparable status, 3) completion of at least one year of graduate medical education in an ACGME approved residency program, and 4) passage of the U.S. Medical Licensing Examination. Once licensed, a physician may legally practice any medical specialty, whether or not he or she has completed a residency program in that specialty. "Board Certified " physicians have completed an ACGME residency program in a specialty and passed the appropriate national certification examination.

Direct Impact on the Colleges of Medicine:

Medical students(undergraduate medical education) and residents(graduate medical education) learn how to provide patient care by observing and assisting medical faculty as they treat patients. The physician's fees, which are charged for this treatment, are billed and collected by entities managed by the colleges of medicine and are referred to as faculty practice plans.
The faculty practice plans constitute the largest single source of funding for the medical schools and include the following revenues: 1) self-pay/other, 2) Medicare Part B Physician Reimbursements, 3) Medicaid, 4) managed care payments, and 5) commercial insurance. Other revenues available to the colleges of medicine include: 1) general revenue, 2) tuition and fees, 3) sponsored contracts and grants, and 4) gifts/endowments/affiliated hospitals/other.

Table 1

University of Florida College of Medicine-1995/96

Revenue Source	Amount	Percent
Gen Revenue	35.1M	10.9%
Sponsored Res	59.6M	18.4%
Faculty Practice	197.8M	61.2%
Gifts/Endow/Other	30.6M	9.5%
Total All	$323.1M	100.0%

University of South Fla College of Medicine-1995/96

Revenue Source	Amount	Percent
Gen Revenue	26.4M	16.3%
Sponsored Res	44.4M	27.4%
Faculty Practice	63.9M	39.4%
Gifts/Endow/Other	27.6M	17.0%
Total All	$162.3M	100.0%

Table 1 reflects revenues available for 1995-96 for UF's and USF'S medical schools. Of the total budget for the UF College of Medicine, sixty-one percent was supported by the faculty practice plan. For USF, thirty-nine percent was supported by the faculty practice plan for the same period. The result is that patient care is cross-subsidizing the education and research activities of the colleges of medicine. The dependence on patient fees makes the medical schools susceptible to: 1) changes in health care delivery caused by managed care, 2) legislative reductions on the number of Medicaid-eligible individuals, and 3) congressional changes in Medicare Part B reimbursement policies.

Expansion of managed health care within the Medicare and Medicaid programs, as well as the general population, will impact the medical school's clinical revenue collections. The State of Florida is shifting approximately 60% of its' Medicaid population from fee-for-service to managed care providers. Nationally, the Medicaid population served by managed care entities has increased from 2.7 million Medicaid patients in 1991 to more than 8 million in 1997. The same trend is occuring with the Medicare population.

Teaching hospitals charge higher fees to cover the direct and indirect costs of their teaching programs and uncompensated care for indigents. HMO's historically prefer to refer patients to facilities that can provide care less expensively than teaching hospitals. The basic premise of controlling costs by minimizing the need for and access to medical services has resulted in a decline in hospital admissions and reduction in length of stay. Changes in hospital utilization affect the physician's ability to generate patient fees. The ability of medical faculty to generate patient fees in outpatient, ambulatory settings is affected by the primary care role of managed care organizations thus minimizing referrals to specialist physicians.

HMO reimbursement rates are expected to decline in the next few years because they are generally set at a percentage of allowable Medicare rates which are also expected to decline. Within the practice plans, each college of medicine has projected an increase(16% University of Florida, 17% University of South Florida, 9% University of Miami) in the proportion of total revenues realized from managed care payments for the period 1995-96 to 2000-2001, as reported in the 1997 Board of Regents study. The Board of Regents updated report, to be completed December 1998, will provide revised revenue estimates.

Federal changes in the formula used to calculate Medicare Part B physician reimbursements are to be implemented with a four-year phase-in beginning January 1, 1999. The formula will move from a historically-based practice management approach(currently, 60% for the physicians salary and 40% to defray practice expense) to a resource-based practice expense formula where specialities will receive varying reimbursement rates. For example, payments to primary care physicians would increase 10% and payments to certain specialists would decrease by 25% to 40% depending on the specialty. This will have an effect on the medical schools because most of their income is from specialty-based care.

Exhibit 1 reflects 1995-96 expenditures by program activity for the University of Florida and the University of South Florida Colleges of Medicine. Of the total $323 million dollar budget for the College of Medicine at the University of Florida, $31 million or 9.6% of the total was associated with the production of the M.D. degree(undergraduate medical education), $45 million or 13.9% was associated with graduate medical education and $76 million dollars or 23.5% was expended for research. For the University of South Florida, $27 million or 16.6% of the total was associated with the production of the M.D. degree, $33 million dollars or 20.2% was associated with graduate medical education and $54 million dollars or 33% was expended for research. The deans have been asked to complete Exhibit I by breaking the total funding out between appropriated and non-appropriated sources.

Exhibit II reflects, for each college of medicine, the revenues used to support undergraduate education for 1995-96. Exhibit II also reflects information previously provided reflecting the costs for the colleges of medicine related to graduate education, however, it did not reflect fund source. These costs are based on the percentage of effort expended by the physician/faculty member in the training and supervision of residents. It is difficult to delineate the cost of graduate medical education because of the: 1)multiple sources for funding and sites of expenditure, 2)complex formulae upon which those funds are awarded, 3)variable internal policies upon which an institution distributes the funds, and 4)the contribution by residents to revenue by assisting the physicians and to expense(malpractice insurance requirements); integral components of their training.

In summary, declines in clinical income generated by the medical school faculty practice results in a loss of revenue to the medical schools. This has an impact on a variety of activities including: 1) restructuring of the

undergraduate education curriculum to produce more primary care physicians, 2) provision of sufficient opportunities for specialty training, 3) construction of community-based, ambulatory outptient clinics, and 4) basic and applied medical research.

Direct Impact on Hospitals:

As is the case with the patient fees billed by the college of medicine faculty, managed care funding policies have impacted the revenue streams for the hospitals. Although the teaching hospitals are implementing procedures to reduce cost and increase efficiency the higher fees charged to cover education costs and uncompensated care for indigent patients makes it difficult to compete for managed care contracts with hospitals that do not have teaching programs. In addition, the decline in the number of individuals admitted and the reduction in the length of stay has affected the revenue streams. Quoting the Board of Regents report, "These trends have begun to seriously affect the quality of medical education and training by reducing medical students', interns' and resident's opportunities to have hands on access to patients."

Although the medical schools incur expense as a result of the faculty effort associated with the training and supervision of residents, the primary source of support for graduate medical education(GME) is provided from the Medicare and Medicaid programs through the hospitals. The Teaching Hospitals have been asked to identify these costs.

As in undergraduate medical education, national organizations, rather than the medical schools, direct the content and organization of the graduate medical education curriculum and approve hospital requests for the various residency programs. These organizations include approximately 24 Residency Review Committees(RRC's) for each specialty operating under the authority of the Accreditation Council for Graduate Medical Education(ACGME) and approximately 23 independent specialty boards that examine and certify specialists and subspecialists. Residency training is conducted primarily in hospitals. Managed Care has resulted in a significant portion of the training being moved into outpatient clinical sites.

As reported by the Board of Regents, "the hospitals make the decisions about the number of residencies to offer and in what specialties rather than the medical schools, the Board of Regents or the Legislature, except that, the decision is jointly determined by the medical school dean and the hospital for academic health centers . In addition, residency positions are not directed to state or regional physician workforce needs or planning efforts."

Medicare is a third party payer that compensates hospitals directly for the direct and indirect costs of medical education as well as the uncompensated care that teaching hospitals typically provide for the disproportionate share of indigent patients they treat. None of these funds are appropriated by the Legislature. Medicare payments for Direct Medical Education(DGME) provide for: 1) costs of residents' stipends and fringe benefits, 2) salaries and fringe benefits for the faculty supervising the residents, 3) direct overhead costs, and 4) allocated institutional costs. Medicare payments for Indirect Medical Education provide: payment recognizing the differences in inpatient operating costs between teaching and non-teaching hospitals. These increased costs are due to a variety of factors including severity, unique services, and the presence of graduate medical education. The Medicare Disproportionate Share(DSH) payment assists hospitals to defray the costs of uncompensated care of low income, indigent and uninsured patients served by teaching hospitals.

The State of Florida does not appropriate any of the federal Medicare funding provided for uncompensated care. State appropriations do provide funding for graduate medical education as a part of the Medicaid Disproportionate Share program. For 1997-98, this totaled $14.9 million dollars.

In addition, the State provides direct funding through the Agency for Health Care to: 1) Shands for uncompensated care and other state programs, 2) Moffitt Cancer Center for research programs and other state programs, 3) each of the three allopathic medical schools for diabetes centers, and 4)the Community Hospital Education Program(CHEP) to support residencies in family practice, internal medicine, obstetrics/gynecology, pediatrics, psychiatry, emergency medicine and internships.

Federal changes in the Medicare program will significantly decrease DME, IME and DSH payments. Currently, direct medical education payments are formula-driven based on each hospital's cost per resident multiplied times the number of residents and the percent inpatient care provided to Medicare recipients. This payment is made for the number of years required to complete the specialty requirements for board certification. The payment is reduced to 50% for each

resident continuing beyond the initial specialty training, with the exception of geriatrics.

Indirect Medical Education payments are formula-driven and provide an increase of approximately 7.7% in the federal portion of the DRG payment for each 10% increase in the hospital's resident-to-bed ratio.

Included in the Conference Committee Report on the Balanced Budget Act of 1997 are the following provisions which will have a negative fiscal impact:

1) formula changes in DME and IME payments, including a freeze at the 1996 level on the number of full-time-equivalent residents.
2) reductions in the IME payment from 7.7% to 5.5% by 2001.
3) a freeze in the Prospective Payment System (PPS) payments for hospital inpatient care.
4) a phased reduction in disproportionate care(DSH) payments beginning in 1998 at 1% and reaching 5% by year 2002.

The Health Care Financing Agency (HFCA) has also announced a 5-year incentive program that will provide payments to hospitals that reduce the number of residencies by 20% to 25%. Under this incentive hospitals will receive full funding for two years, after which the funding will decline to zero. Hospitals that have relied heavily on residents to provide patient care will be required to replace these residents with other, more expensive health care providers. In addition, such a policy will disproportionately affect Florida which currently ranks 41st nationally in the number of resident physicians per 100,000 population.

The Medicaid program does not make direct payments to hospitals for medical education; however, due to the higher costs incurred at the teaching hospitals, one could make the statement that medical education has been indirectly funded through the cost reimbursement process. Similar to Medicare, the Medicaid program also makes disproportionate share payments. The Balanced Budget Act of 1997 contains provisions that will reduce Medicaid DSH payments. It is anticipated that Florida will receive increased DSH payments for fiscal years 1997-1999 but by 2001, the proposed allocation is less than fiscal year 1995.

The role of the Medicare program, including the funding of graduate medical education, is undergoing substantial review by two major governmental commissions: 1) the National Bipartisan Commission on the Future of Medicare, 2) the Pew Charitable Trusts' Health Professions Commission. Both groups are expected to release reports soon.

On August 10, 1998 the National Bipartisan Commission on the Future of Medicare discussed the issue of graduate medical education and its relationship to Medicare. There was no agreement on: 1) how GME should be funded, 2) what the role of Medicare should be, and 3) how, or if, medical schools and teaching hospitals should be held more accountable for the funds they receive. Proposals currently before the commissioners include:1) removal of DGME, IME and DSH payments from the Medicare program and funding with general revenue through the federal appropriations process, 2) creating a GME trust fund, and 3) implementation of a voucher system.

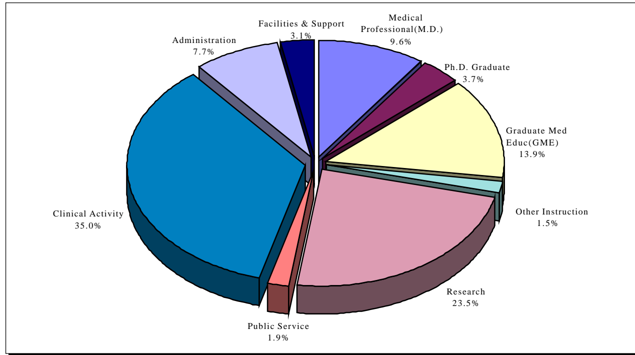
RECOMMENDATIONS

1) Subsequent to the 1999 session, the Legislature should consider the establishment of a task force including representatives from the four medical colleges and the teaching hospitals to do the following:

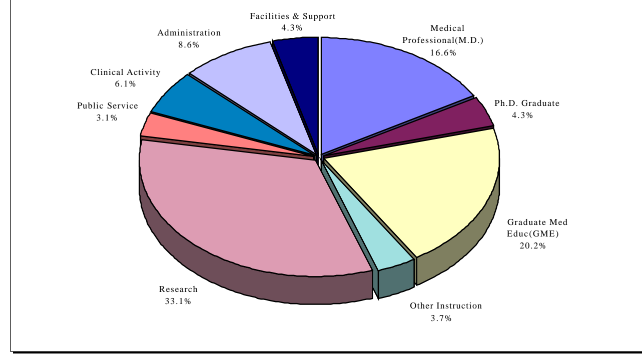
A) Review and respond to the work of the two national committees.
B) Review and respond to the Board of Regents/FSU independent study of undergraduate and graduate medical education.
C) Develop more current and complete information for undergraduate and graduate medical education costs for the the medical colleges and teaching hospitals.
D) Develop a better understanding of the Graduate Medical Education costs incurred by the Colleges of Medicine versus the hospitals, including a potential double counting of expenditures.
E) Develop a better understanding of the differences in disproportionate share paid for by the Federal Government through Medicare and Medicaid & the State's disproportionate share program.
F) Assess the financial impact of the Balanced Budget Amendment of 1997.
G) Assess the financial impact of other funding pressures.
H) Assess the role of the state in the financing of undergraduate and graduate medical education.

Exhibit I

U F College of M edicine
1995-96 Expenditures By Program Area



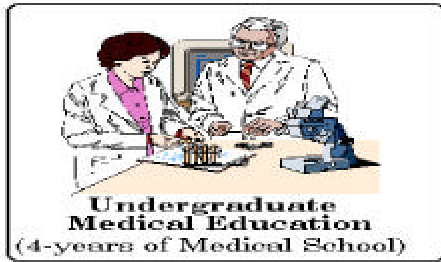
U SF College of M edicine
1995-96 Expenditures By Program Area



Program Activity	Appro $ (M illions)	Non-Appro $ (Millions)	Total $ (Millions)	Pct.
Instruction				
M edical Professional(M .D.)	$ -	$ 31	$ 31	9.6%
Ph.D. Graduate	$ -	$ 12	$ 12	3.7%
Graduate M ed Educ(GME)	$ -	$ 45	$ 45	13.9%
Other Instruction	$ -	$ 5	$ 5	1.5%
Subtotal - Instruction	$ -	$ 93	$ 93	28.8%
Research		$ 76	$ 76	23.5%
Public Service	$ -	$ 6	$ 6	1.9%
Clinical Activity	$ -	$ 113	$ 113	35.0%
Administration	$ -	$ 25	$ 25	7.7%
Facilities & Support	$ -	$ 10	$ 10	3.1%
Total All Activites	$ -	$ 323	$ 323	100.0%

Program Activity	Appro $ (M illions)	Non-Appro $ (M illions)	Total $ (M illions)	Pct.
Instruction				
Medical Professional(M.D.)	$ -	$ 27	$ 27	8.4%
Ph.D. Graduate	$ -	$ 7	$ 7	2.2%
Graduate M ed Educ(GM E)	$ -	$ 33	$ 33	10.2%
O ther Instruction	$ -	$ 6	$ 6	1.9%
Subtotal - Instruction	$ -	$ 73	$ 73	22.6%
Research		$ 54	$ 54	16.7%
Public Service	$ -	$ 5	$ 5	1.5%
Clinical Activity	$ -	$ 10	$ 10	3.1%
Administration	$ -	$ 14	$ 14	4.3%
Facilities & Support	$ -	$ 7	$ 7	2.2%
Total All Activites	$ -	$ 163	$ 163	50.5%

Exhibit II



TOTAL REVENUE	UF $30.8M	USF $27.3M	UM $20.9M
Sources:			
Tuition		8.50%	26.80%
General Revenue	12.40%	19.00%	26.80%
Contracts & Grants	27.80%	15.10%	3.90%
Faculty Pratice	43.30%	46.20%	27.50%
G ifts/Edowments/Affil Hosp	16.50%	11.20%	15.00%
Total Percentage	100.00%	100.00%	100.00%
# Medical Students	460	384	545
Annual Cost per Med Stu:			
Direct:	$61,500	$67,500	$70,400
Full Cost:	$67,000	$71,100	$93,300
Four-year Full Cost:	$268,000	$284,400	$373,200

TOTAL REVENUE	UF $45.0M	USF $33.00	UM
Sources:			
General Revenue			
Contracts & Grants			
Faculty Pratice			
G ifts/Edowments/Affil Hosp			
Total Percentage	100.00%	100.00%	100.00%
# Residents			
Annual Cost per Resident:			
Direct:			
Full Cost:	$52,088	$59,000	$79,000
Three-year Cost:	$156,264	$177,000	$237,000
Five-year Cost:	$260,440	$295,000	$395,000

COMMITTEE(S) INVOLVED IN REPORT ***(Contact first committee for more information.)***
Committees on Ways and Means, Subs B & C, 404 South Monroe Street, Tallahassee, FL 32399-1100, (850) 487-5140 SunCom 277-5140
Committee on Education
Committee on Health Care

MEMBER OVERSIGHT
Senators Donald Sullivan, Jim Horne, and Anna Cowin