

**IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION**

Case No. 9:25-cv-80526-DMM

GOOD SAMARITAN MEDICAL CENTER,
INC., et al.,

Plaintiffs,
v.

THE LEAPFROG GROUP,

Defendant.

**DEFENDANT’S DAUBERT MOTION TO EXCLUDE EXPERT TESTIMONY
AND SUPPORTING MEMORANDUM OF LAW**

Pursuant to Federal Rules of Evidence 402, 403, and 702, and *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 578 (1993), Defendant, The Leapfrog Group (“TLG”), respectfully moves to exclude the opinions and testimony of Plaintiffs’ purported expert witnesses Thomas Chakurda, Jonah Berger, Ph.D., and Sean Nicholson, Ph.D. Grounds for this Motion are set forth in the accompanying Memorandum of Law.

MEMORANDUM OF LAW

Background

The Plaintiffs are five hospitals operating in South Florida. [ECF No. 74, ¶¶ 7-11] TLG is a 501(c)(3) nonprofit corporation focused on improving patient safety at hospitals. [*Id.* ¶ 12] Among other things, TLG issues “Hospital Safety Grades” to hospitals throughout the country and publishes them on its website, www.hospitalsafetygrade.org. [*Id.* ¶ 18] Those safety grades are based, in part, on scores derived from information that hospitals provide to TLG in response to a survey, if a hospital chooses to participate in the survey. For those hospitals that do not respond, TLG imputes scores for four (4) of the twenty-two measures in calculating the safety grade. [ECF

No. 75, Answer ¶ 20]

Plaintiff Hospitals have elected not to provide survey information to TLG during recent grading periods. [*Id.* Answer ¶ 57] Now, they are disappointed with their most recent safety grades and have filed a two-count Amended Complaint against TLG alleging violations of the Florida Deceptive and Unfair Trade Practices Act (“FDUTPA”). [ECF No. 74] In Count I, a claim for violation of FDUTPA, Plaintiff Hospitals seek injunctive relief. In Count II, they seek a declaration that TLG’s grading system violates FDUTPA. [*Id.* at pp. 38. 40]

Plaintiffs’ Expert Reports

In support of their claims, Plaintiff Hospitals have proffered the opinions of three purported expert witnesses, Thomas Chakurda, Jonah Berger, Ph.D, and Sean Nicholson, Ph.D.

Mr. Chakurda. Mr. Chakurda states that he has more than 40 years’ experience in marketing and public relations related to the healthcare industry. [Chakurda Rep. ¶ 3, attached as **Exhibit A**] As discussed below, he proffers two opinions, but his “Expert Report of Thomas Chakurda” does not identify any particular methodology utilized in arriving at those opinions. Instead, he appears to rely on his experience and his reading as the bases for his proposed testimony.

(1) For his first opinion, Mr. Chakurda asserts that a hospital’s brand is critical to its “reputation and economic success” and thus that “a strong hospital brand impacts all of the hospital’s stakeholders because it drives patients and caregivers to choose that hospital, and also increases patient referrals and doctor and staff recruitment and retention.” [*Id.* ¶

12

(2) Second, Mr. Chakurda maintains that “hospitals who receive low TLG grades experience reputational harm to their brand.” [*Id.* ¶ 13]

Dr. Berger. Dr. Berger is a Marketing professor at the Wharton School at the University of Pennsylvania. [Berger Rep. ¶ 1, **Exhibit B**] He offers three opinions as discussed below. Like Mr. Chakurda, his “Expert Report of Jonah Berger, Ph.D.” does not identify a particular methodology utilized to arrive at his opinions, but instead seems to rely primarily on academic papers, including a few as to which he was an author or co-author.

(1) Dr. Berger’s first opinion is that “TLG’s ‘D’ or ‘F’ Hospital Safety Grades for Plaintiff Hospitals likely impact consumers [sic] perceptions of the Plaintiff Hospitals and deter consumers from choosing to receive care there.” [*Id.* ¶ 15]

(2) His second opinion is that “if TLG continues to publish low or failing grades from Plaintiff Hospitals in the future, these effects are likely to be amplified.” [*Id.*]

(3) Finally, Dr. Berger’s third opinion is that “[w]hile TLG purports to disclose its imputation methodology to consumers, consumers are unlikely to understand that TLG assigns the minimum possible score on imputed measures and the impact of the imputation methodology on the Hospital Safety Grades for non-participating hospitals.” [*Id.*]

Dr. Nicholson. Dr. Nicholson is an economics professor at Cornell University. [Nicholson Rep. ¶ 1, **Exhibit C**]

(1) Dr. Nicholson first opines that “TLG’s hospital grades are far from reliable or transparent.” [*Id.* ¶ 18]

(2) His second opinion is that “TLG’s methodology departs from guiding principles for how hospital quality or safety should be measured.” [*Id.* ¶ 19]

Applicable Legal Standards

Federal Rule of Evidence 702 governs the admissibility of expert testimony. *See Rink v. Cheminova, Inc.*, 400 F.3d 1286, 1291 (11th Cir. 2005). “Under Rule 702 and *Daubert*, district

courts must act as ‘gatekeepers’ which admit expert testimony only if it is both reliable and relevant.” *Id.* (quoting *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 589 (1993)). “The importance of *Daubert*’s gatekeeping requirement cannot be overstated.” *United States v. Frazier*, 387 F.3d 1244, 1260 (11th Cir. 2004). Courts act as gatekeepers to ensure that “speculative, unreliable expert testimony” is not presented to the fact finder as evidence deemed reliable because it reflects ostensible expertise. *Banta Properties, Inc. v. Arch Specialty Ins. Co.*, No. 10-61485-CIV, 2011 WL 13096476, at *1 (S.D. Fla. Dec. 22, 2011) (quoting *Rink*, 400 F.3d at 1291); *see McCorvey v. Baxter Healthcare Corp.*, 298 F.3d 1253, 1256 (11th Cir. 2002) (noting that speculative, unreliable testimony should not reach the fact finder).

Further, “Rule 702 still requires district courts to exclude unreliable or unhelpful expert testimony, even in a bench trial.” *X Social Media LLC v. X Corp.*, 6:23-cv-1903-JA-NWH, 2025 WL 2578249, at *2 (M.D. Fla. Sept. 5, 2025) (granting Defendant’s *Daubert* motion and denying Plaintiff’s *Daubert* motion). *See also Broberg v. Carnival Corp.*, No. 17-CV-21537-MORENO/LOUIS, 2018 WL 47784557 (S.D. Fla. June 11, 2018) (noting that, notwithstanding relaxed procedure, courts have routinely analyzed and granted *Daubert* motions prior to a bench trial, and granting in part and denying in part the parties’ *Daubert* motions), *report and recommendation adopted*, 2018 WL 4776386 (S.D. Fla. July 3, 2018).

In particular, Rule 702 provides that:

A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if the proponent demonstrates to the court that it is more likely than not that:

- (a) the expert’s scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;
- (b) the testimony is based on sufficient facts or data;
- (c) the testimony is the product of reliable principles and methods; and

- (d) the expert's opinion reflects a reliable application of the principles and methods to the facts of the case.

Fed. R. Evid. 702.

For courts to perform their gatekeeping function, the Eleventh Circuit has set forth a “rigorous three-part inquiry.” *U.S. v. Frazier*, 387 F.3d 1244, 1260 (11th Cir. 2004). Courts must consider whether: “(1) the expert is qualified to testify competently regarding the matters he intends to address; (2) the methodology by which the expert reaches his conclusions is sufficiently reliable as determined by the sort of inquiry mandated in *Daubert*; and (3) the testimony assists the trier of fact, through the application of scientific, technical, or specialized expertise, to understand the evidence or to determine a fact in issue.” *Id.* The Eleventh Circuit refers to these as the “qualifications,” “reliability,” and “helpfulness” inquiries. *Id.*

An opinion is not helpful to the trier of fact if the average layperson is “capable of understanding an issue without the aid of an expert.” *United States v. Navedo-Ramirez*, 781 F.3d 563, 568 (1st Cir. 2015) (citing *United States v. Salimonu*, 182 F.3d 63, 74 (1st Cir. 1999)) (affirming district court’s exclusion of expert testimony regarding battered woman syndrome and duress in part because threats defendant received were such that “any person could readily appreciate their impact”).

Likewise, an opinion that disregards actual, readily-obtainable information, and is not tethered to the actual facts of the case, should be excluded. *Laumann v. Nat’l Hockey League*, 117 F. Supp. 3d 299, 315 (S.D.N.Y. 2015); *Sheffield v. Int’l Paper Co.*, No. 2018-CV-02701-JPM-CGC, 2020 WL 1882906 (W.D. Tenn. Feb. 26, 2020).

“The party offering the expert has the burden of satisfying each of these three elements by a preponderance of the evidence.” *Rink*, 400 F.3d at 1292; see *Ho v. Royal Caribbean Cruises Ltd.*, No. 18-23541-CIV, 2020 WL 5534278, at *1 (S.D. Fla. Aug. 4, 2020) (“When a party proffers the

testimony of an expert under Rule 702 of the Federal Rules of Evidence, the party offering the expert testimony bears the burden of laying the proper foundation, and that party must demonstrate admissibility by a preponderance of the evidence.”).

Argument

I. Mr. Chakurda’s Testimony Should Be Excluded.

Mr. Chakurda was asked to provide opinions on (1) “the role of hospital rating systems, including TLG’s grades, in the brand management and marketing of hospitals” and (2) “the reputational impact of receiving negative TLG grades for hospitals.” [Chakurda Rep. ¶ 2, **Ex. A**]. Specifically, Mr. Chakurda opined that “[a] hospital’s brand—which is fostered and publicized by hospital marketing— is critical to a hospital’s reputational and economic success.” [*Id.* ¶ 12]. Mr. Chakurda also opined that “hospital ratings are a significant part of how a hospital is perceived in the community” and “hospitals who receive low TLG grades experience reputational harm to their brand.” [*Id.* ¶ 13]. These opinions are not admissible because they do not assist the trier of fact to determine a material issue of fact and are not based on sufficient facts or data.

A. The proffered opinions will not help the trier of fact to understand the evidence or determine a fact in issue.

As a preliminary matter, none of Mr. Chakurda’s opinions are “helpful” as required by Rule 702 and the Eleventh Circuit because they address general ideas which are not material issues to the case. A proponent of an expert witness must demonstrate to the court that it is more likely than not that the expert’s scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue. Fed. R. Evid. 702(a). “[E]xpert testimony is admissible if it concerns matters that are beyond the understanding of the average lay person,” but not “when it offers nothing more than what lawyers for the parties can argue in closing arguments.” *Blue Chip Alliance, LLC v. Chetu, Inc.*, 2025 WL 50391, at *11 (S.D. Fla. Jan. 8,

2025) (quoting *U.S. v. Frazier*, 387 F. 3d 1244, 1262-63 (11th Cir. 2004)). Further, expert testimony must fit the facts of the case, meaning that it must “logically advance[] a material aspect of the case.” *Id.* at *4 (citing *McDowell v. Brown*, 392 F. 3d 1283, 1298-99 (11th Cir. 2004)).

Here, Mr. Chakurda’s Report does not “concern matters that are beyond the understanding of the average lay person,” but instead addresses general, readily understood marketing concepts. For example, Mr. Chakurda opines that “[h]ospital rating systems impact a hospital’s brand and reputation” and “can impact how the hospital is perceived.” [Chakurda Rep. ¶ 31, **Ex. A**]. Plainly, this generally is the purpose of a rating system. He even argues that “[i]t is *well-known* that these types of hospital ratings can provide market differentiation” [*id.* ¶ 34 (emphasis added)] and provides no explanation for why an expert is needed to explain something purportedly so well-known and understood.

Mr. Chakurda’s Report also does not meet the helpfulness requirement because it does not advance a “material aspect of the case.” The relevant issues or factual disputes remaining in this case revolve around whether the methodology utilized by TLG to assign grades is “unfair,” whether consumers were “deceived” by TLG’s publications as to how the grades were calculated, whether Plaintiff Hospitals are “aggrieved” by the grades, and whether any purportedly unfair or deceptive conduct by TLG has actually harmed any consumers. Mr. Chakurda’s Report does not address any of these issues.

Instead, Mr. Chakurda opines about general concepts such as the notion that higher “A” or “B” grades are good for a hospital’s brand while lower grades are bad. Expert analysis is not needed to understand this issue. Every school child can appreciate the fact that an A grade is good and an F bad; similarly, it does not take an expert to appreciate that some consumers might care about patient *safety* ratings when choosing a *health care provider*. Thus, to the extent that Mr.

Chakurda's expertise is used only to support the general concept that positive (or A) ratings are good for a hospital's brand and negative (or F) ratings are bad, no expertise is needed to explain this issue to the Court. Because Mr. Chakurda's opinions do not address the facts in issue and instead focus on undisputed issues, his opinions are not "helpful" to the trier of fact as required by Rule 702.

Moreover, Mr. Chakurda's Report frequently conflates the issues in this case, leading to greater confusion, not greater clarity. For example, as part of his opinion that negative TLG grades impair a hospital's brand, Mr. Chakurda spends an entire section of his Report arguing that hospitals who earn *positive* TLG grades must expend money to fully *capitalize* on those grades. [Chakurda Rep. ¶¶ 37-44, **Ex. A**]. Yet the marketing funds a hospital may *choose* to spend to promote a positive rating – or any other quality of their hospital which they perceive to be favorable – are not material to whether the ratings awarded to and published about Plaintiff hospitals were accurate or deceptive.

Mr. Chakurda introduces this section of his Report by noting that "efforts to participate in the Leapfrog Hospital Survey are on top of mandatory reporting obligations" and "there is a general lack of harmony and standardization among the various third-party rating organizations, leading to additional expenditure and effort" [*id.* ¶ 37], thus creating the misleading impression that there is a significant cost to participate in the TLG survey, as opposed to a marketing cost to promote the grade awarded above and beyond TLG's publication of it. TLG does not dispute that once it awards grades, hospitals who earn a positive grade have a variety of options for promoting that grade, including options that are wholly free, options that require payment to TLG, and options that could require payment to other entities. This is wholly irrelevant to how TLG calculates the grades or how TLG discloses the methodology in its own publications. In effect, Mr. Chakurda's

Report is an attempt to argue the same points that Plaintiffs' counsel could argue in closing argument, but dressed up as expert testimony. Accordingly, it should be excluded.

B. The proffered opinions are not based on a reliable methodology applied to sufficient facts or data.

As described above, Mr. Chakurda's Report primarily puts forth general, easily understandable and largely uncontested concepts. However, to the extent that Mr. Chakurda attempts to draw any more detailed conclusions about the impact on the specific Plaintiff Hospitals due to the contested grades, including addressing the difference in impact between the grades actually assigned and the best grades available, he offers no reliable facts or methodology.

The best evidence of the actual impact on Plaintiff hospitals' reputation and brand would be consumer surveys and/or data from the Hospitals in the form of patient testimony, patient data, and financial data such as revenue and marketing budget. Mr. Chakurda acknowledges that the only methodology he is aware of for assessing a company's brand is conducting consumer surveys. [Dep. Tran. of Thomas Chakurda ("Chakurda Tr.") 18:21-19:4, **Exhibit D**].

Yet Mr. Chakurda did not conduct any survey and does not appear to have asked for or had access to any relevant Hospital data on patient numbers or revenue. He even testified that, in forming the opinions and conclusions in his Report, he did not speak to anyone at any of the Plaintiff Hospitals, did not review any marketing plans from any of the Plaintiff Hospitals, did not take any surveys, and, as to the actual quality of the Plaintiff Hospitals, appears to have relied solely on his own perception of the Plaintiff Hospitals from working for competitors in the industry, prior to their purchase by the current ownership roughly seven years ago. [*Id.* 17:21-18:5, 18:21-20:22, 26:9-20] Specifically, when asked whether he utilized any scientific methodologies in forming his opinions or conclusions, he could answer only that his opinions were based on his "marketing experience" and his "impression of the impact that D or F would have on their brand."

[*Id.* 26:13-20]. This is insufficient to support a proper expert opinion. See *Umana-Fowler v. NCL (Bahamas) Ltd.*, 49 F. Supp. 3d 1120 (S.D. Fla. 2014) (noting that expert cannot merely rely on “experience” without proper explanation of application to data, and cautioning against admitting inference or an opinion that is too great a leap from the data).

Further, Mr. Chakurda complains in his expert Report that he has not yet had the opportunity to meaningfully review documents produced by TLG, and therefore reserves the right to “adjust” his opinions. [Chakurda Rep. ¶ 56, **Ex. A**]. Yet any evidence of actual impact to Plaintiffs’ reputation – the topic Mr. Chakurda purports to opine about – would presumably come from his own clients in the form of patient testimony, patient data, and financial data such as revenue and marketing budget. TLG does not have that information – indeed, TLG attempted to obtain the relevant data from Plaintiffs in discovery, and Plaintiffs responded by withdrawing their claims for actual damages in order to avoid producing such discovery. Mr. Chakurda’s report is nothing more than an attempt by Plaintiffs to avoid producing the actual data and evidence that would show whether they were materially impacted by the change to their grades, and to instead “prove” that they were harmed through speculation disguised as expert testimony. Because expert opinions must be based on the proper application of reliable methodologies to sufficient facts or data, and may not be used to *avoid producing* the actual data, Mr. Chakurda’s testimony should be excluded.

II. Dr. Berger’s Testimony Should Be Excluded.

A. Dr. Berger’s first and second opinions should be excluded.

1. The proffered opinions will not help the trier of fact to understand the evidence or determine a fact in issue.

“[E]xpert testimony is admissible if it concerns matters that are *beyond the understanding of the average lay person*. Proffered expert testimony generally will not help the trier of fact when

it offers nothing more than what lawyers for the parties can argue in closing arguments.” *Cook ex rel. Estate of Tessier v. Sheriff of Monroe County, Fla.*, 402 F.3d 1092, 1111 (11th Cir. 2005) (quoting *U.S. v. Frazier*, 387 F.3d 1244, 1262-63 (11th Cir. 2004) (en banc)) (emphasis added). In other words, expert testimony is admissible if it offers something “beyond the understanding and experience of the average citizen.” *U.S. v. Rouco*, 765 F.2d 983, 995 (11th Cir. 1985).

Accordingly, in *Estate of Tessier*, the Eleventh Circuit affirmed the exclusion of expert testimony that “concern[ed] matters that arguably lie within the understanding of the average lay person” because it was “unnecessary.” *Estate of Tessier*, 387 F.3d at 1111. *See also U.S. v. Castaneda*, 997 F.3d 1318, 1331 (11th Cir. 2021) (affirming exclusion of expert testimony because “[e]veryone knows people sometimes lie and that the internet does not filter out falsehoods” and “[n]o juror needs expert help understanding that concept”); *Demboske v. Autry Greer & Sons*, 740 F. Supp. 3d 1172, 1179 (N.D. Fla. 2024) (excluding as not helpful expert’s opinion that “wet floors are hazardous” because such knowledge “is within a layperson’s knowledge”); *Hyde Park Storage Suites Daytona, LLC v. Crown Park Storage Suites, LLC*, 631 F. Supp. 3d 1203 (M.D. Fla. 2022) (excluding expert opinion as not helpful because it was not different “from what attorneys can argue at trial”).

As noted above, Dr. Berger’s first and second opinions relate to whether a “D” or “F” grade from TLG, now or in the future, might negatively impact consumer perception of the Plaintiff Hospitals. Dr. Berger never explains why these concepts would be difficult for the average person to understand, and with good reason: it is undoubtedly a matter of common knowledge that “D” and “F” are poor grades, just as it is common knowledge that “A” and “B” are good grades. There is no need for a \$1200-per-hour “expert” to explain these concepts to the Court.

Moreover, Dr. Berger never considered whether the Plaintiff Hospitals are deserving of

“D” and “F” grades. [Dep. Tran. of Jonah Berger (“Berger Tr.”) 28:13-22, **Exhibit E**] His Report does not assess in any manner whether the Plaintiff Hospitals provide their patients with appropriately safe care. As he testified, “I’m not putting forth an opinion about the actual quality of these hospitals.” [*Id.* 99:18-22] Nor does he consider the impact of the negative grades the Plaintiff Hospitals have received from other grading platforms, including CMS, Yelp, and *U.S. News & World Report*. [*Id.* 99:7-17; 107:11-20; 111:2-7; 111:23-112:1] In other words, he did not consider and provides no reliable opinion as to whether the TLG grades at issue in this lawsuit actually had or could have had any impact on consumer perceptions of the Plaintiff Hospitals. Because his opinion is obvious but also is not tethered to and fails to address or account for real world events, it is not helpful. As a result, it should be excluded from the trial of this matter.

2. The proffered opinions are not based on sufficient facts or data.

Dr. Berger’s first and second opinions also should be excluded because they are not based on sufficient facts or data. In particular, Dr. Berger opines that not only can “D” and “F” grades negatively impact consumer opinion of the hospitals, but also that these grades, published now or in the future, will likely “deter consumers from choosing to receive care” at the Plaintiff Hospitals. In essence, his expert testimony is that the Plaintiff Hospitals likely lost patients – and the associated revenue – because the TLG grades dissuaded patients from seeking treatment at the Hospitals. Presumably, the purpose of this proffered testimony is to establish that the Plaintiff Hospitals were “aggrieved” within the meaning of FDUTPA.

But the best and most probative evidence of whether the TLG grades caused the Plaintiff Hospitals to lose patients or revenue would be empirical evidence of *actual* patient admissions and *actual* revenue, before and after the TLG grades were announced. And the best sources for this information, of course, would be the Plaintiff Hospitals themselves, which undoubtedly have records reflecting the number of patients admitted to their hospitals, the medical procedures or

treatment provided, and the fees received before and after TLG issued its grades. But Dr. Berger did not consider any of this evidence. In fact, it appears that he never even asked for it.

Rule 702(b)'s requirement that expert testimony be based upon sufficient facts or data goes to the issue of reliability. "Reliability of the methodology requires an exacting analysis of the proffered expert's methodology." *Banuchi v. City of Homestead*, 606 F. Supp. 3d 1262, 1269 (S.D. Fla. 2022) (internal quotation omitted). One of the key factors in testing reliability is "whether the expert's methodology can be, and has been, tested." *Id.* Here, Dr. Berger's opinion that the TLG grades deterred patients from choosing to receive treatment at the Plaintiff Hospitals certainly *can be tested*. As noted above, at its most basic, it can be tested by comparing the number of patients who received treatment from the Hospitals before and after the TLG grades were issued. But Dr. Berger never undertook this analysis. [*See, e.g.*, Tr. 131:7-14 (Dr. Berger testifying that he had no empirical data on how the difference between a "C" and "D" grade impacts consumer perception of hospitals)]

The appropriate methodology for comparing the before-and-after patient admissions would, of course, need to account and control for other factors that might influence the number of patients receiving treatment from the Plaintiff Hospitals, among other things. And the precise methodology would need to be rigorously planned out to account for unforeseen factors. But not only did Dr. Berger not employ or describe such a methodology, he does not even claim to have the expertise to formulate or implement it.

Similarly, Dr. Berger never interviewed any patients or potential patients at the Plaintiff Hospitals and did not conduct any type of survey to determine why individuals decided to seek (or not seek) treatment there. He did not review any patient questionnaires or correspondence or any other types of patient/hospital communications to assess why patients were or were not electing to

seek treatment from the Hospitals. He does not even know if the Plaintiff Hospitals conduct their own patient satisfaction surveys. [Berger Tr. 102:11-17] And yet, as he acknowledged, consumer survey information is often the best data to answer relevant questions about consumer behavior, and Dr. Berger himself has undertaken “over a thousand surveys in combination of [his] academic and expert work.” [*Id.* 77-78] But he conducted no surveys here.

Nor did he consider data of any kind from the Hospitals themselves, including any data from the Hospitals’ admissions departments or marketing departments or patient safety officers. In fact, Dr. Berger never spoke to any employees or officers of the Plaintiff Hospitals when formulating his opinions. [*Id.* 24:14-23]

Tellingly, Dr. Berger recognizes that his opinion about the impact of TLG grades on the Plaintiff Hospitals is meant to parallel the results of real-world studies in other contexts, studies that are based on actual, measurable results and empirical data. Thus, his Report states that

In the restaurant industry, for example, a 2002 study found that, after the introduction of mandatory hygiene grade rating disclosures using letter grades, consumer demand increased for restaurants that received higher grades. In particular, restaurants that received “A” and “B” grades experienced *statistically significant increases in revenue* after the introduction of the grades. In the education context, a 2004 study found that, after the introduction of a statewide evaluation system for public schools in Florida using letter grades, the sales price of houses zoned for schools that received “A” grades *increased 19.5% relative to* the houses zones for schools that received “B” grades.

[Berger Rep. p. 14 (emphasis added; footnotes omitted)] The studies cited by Dr. Berger considered empirical data evidencing the impact of grades on revenue and sales prices. That is, they considered and assessed the precise types of data that Dr. Berger elected *not* to consider – or that the Plaintiff Hospitals were *not* willing to provide him – when formulating his opinions here. In stark contrast to Dr. Berger’s opinion, the studies Dr. Berger cites arrive at their conclusions

based upon sufficient data and facts.¹

The reason Dr. Berger did not consider such information here is obvious: his employers in this case, the Hospitals, did not want him to review the information, likely because it would undermine his opinions. When this case was first filed, the Plaintiff Hospitals included a claim for actual damages. But when TLG served discovery seeking information about alleged declines in patient admissions or lost patient revenue, among other things, the hospitals made an about-face and dropped their actual damages claim. This allowed them to avoid disclosing critical information about whether the TLG grades *in fact* deterred patients from selecting to receive treatment at the hospitals. But having chosen to hide empirical evidence as to whether the TLG grades negatively impacted patient admissions, the Hospitals should not now be permitted to proffer purported expert opinion testimony on the likelihood that that occurred. This is classic, impermissible sword and shield conduct. *See, e.g., BPI Sports, LLC v. ThermoLife Int'l LLC*, No. 19-60505-CIV-SMITH, 2020 WL 10180911, at *2 (S.D. Fla. Jun. 4, 2020) (Prohibiting defendants from using discovery posture as both sword and shield. “To do so frustrates not only Plaintiff’s ability to litigate its case, but also stymies discovery in this action.”).

Dr. Berger’s Supplemental Expert Report makes the importance of empirical data even clearer. In his Supplemental Report (submitted two weeks after his original Report), Dr. Berger reviewed and opined on the purported significance of Google Analytics website data about the TLG website. That specific data was not available to him when he authored his initial Report but became available later. Based upon the data, he states in his Supplemental Report that, in his

¹ Remarkably, Dr. Berger simply *assumes* that all the relevant information he needed was provided to him. [See Berger Tr. 104:13-16 (“I asked for information that was relevant to forming my opinions. And I trust that I was given anything that was relevant to forming my opinions.”)]

original Report, “I also explained that many consumers are unlikely to see, let alone read, TLG’s Spring 2025 ‘Scoring Methodology’ document. TLG’s Website Analytics Data corroborates this conclusion.” [Supp. Rep. ¶ 5, **Exhibit B**] In other words, Dr. Berger recognized that it was important to review empirical data *available from TLG* to see if it was consistent with his purported expert opinion. But as explained above, Dr. Berger did not consider, or even ask for, empirical data *available from the Plaintiff Hospitals* to see if it was consistent with his opinions about whether patients were deterred from seeking treatment there. This methodological inconsistency renders Dr. Berger’s first and second opinions unreliable and inadmissible under Rule 702.

B. Dr. Berger’s third opinion should be excluded.

Dr. Berger’s third opinion – that “consumers are unlikely to understand that TLG assigns the minimum possible score on imputed measures and [or understand] the impact of the imputation methodology on the Hospital Safety Grades for non-participating hospitals” – should also be excluded for a variety of reasons.

First, although Dr. Berger purports to explain how consumers would encounter and navigate TLG’s website, he acknowledges that he has no expertise in website design. Nor does he have any expertise in “digital low literacy.” [Berger Tr. 13:17-22; 14:2-5] As a result, he is not qualified to opine on the means by which consumers encounter, interact with, and understand websites.

Second, as explained above, Dr. Berger acknowledged that consumer surveys are likely the best method for assessing consumer conduct, but Dr. Berger did not undertake any surveys to support his analysis. In particular, he never asked consumers the most basic question: did they understand the website’s disclosures about TLG’s methodologies (or anything else)? [*Id.* 52:6-53:2; 62:7-18] Rather than asking this question and gathering empirical data about consumer

understanding of the website, he simply navigated the website himself and read the webpages. Of course, if that is all that is required to assess consumer understanding, the Court can do the same thing, and the parties' lawyers can argue about the meaning of the various webpages.

Third, while Dr. Berger opines that consumers are not likely to understand TLG's disclosures about its imputation method, he did not consider, and provides no opinion, on the obvious corollary question – if he believes that the TLG website does not properly disclose information about the imputation method, how could the website do so? [*Id.* 72:12-22] Since Dr. Berger did not consider and cannot offer an alternative method to disclose information in a way that consumers would understand, his opinion provides no help on addressing the critical issue of whether there is a “better” way to disclose the imputation information to consumers to avoid alleged deception. In other words, his opinion is not helpful in addressing the question of whether, as Plaintiffs allege, the website disclosures are “deceptive.” For this additional reason, his testimony as to his third opinion should be excluded.

III. Dr. Nicholson's Testimony Should Be Excluded.

The crux of Dr. Nicholson's opinion is that “hospitals that participate in TLG's survey are unfairly advantaged” over Plaintiffs and other hospitals that do not participate. [Nicholson Rep. ¶ 3] This opinion, and the rest of Dr. Nicholson's report and testimony, is not tethered to the actual facts of this case. For that reason, Dr. Nicholson's testimony should be excluded. As noted above, an expert opinion must be “based on sufficient facts or data” and “reflect[] a reliable application of the principles and methods to the facts of the case.” Fed. R. Evid. 702(b) & 702(d). In other words, an expert opinion must not rest upon generalities but instead must take into account the actual facts of the case. As the U.S. Supreme Court explained in upholding the exclusion of an expert's testimony:

The question before the trial court was specific, not general. The trial court had to decide

whether this particular expert had sufficient specialized knowledge to assist the jurors “in deciding the particular issues in the case.”

Kumho Tire Co., Ltd. v. Carmichael, 526 U.S. 137, 156 (1999) (quoting 4 J. McLaughlin, Weinstein’s Federal Evidence ¶ 702.05[1], p. 702–33 (2d ed.1998)). Accordingly, an expert opinion that “is largely untethered from the actual facts of this case” should be excluded. *Laumann v. Nat’l Hockey League*, 117 F. Supp. 3d 299, 315 (S.D.N.Y. 2015).

For example, in *Laumann*, an economist offered an opinion concerning how consumers would respond if sports leagues dropped restrictions on out-of-market access to regional television broadcasts. *Id.* at 302-03. The economist’s estimates did “not rely on sufficient data about consumer tastes and preferences,” the court found. *Id.* at 315. “Instead, time and time again, [the economist] substitute[d] mathematical assumptions for actual, readily-obtainable information.” *Id.* Because the economist did not rely upon “sufficient facts or data,” his testimony about consumer demand was excluded. *Id.* at 319.

Similarly, in *Sheffield v. Int’l Paper Co.*, No. 2018-CV-02701-JPM-CGC, 2020 WL 1882906 (W.D. Tenn. Feb. 26, 2020), a district court considered an economist’s report that “relie[d] on general statistics about average Americans.” *Id.* at *4. The report was “untethered from actual known factual data on the Plaintiff in the case,” including the plaintiff’s “individual traits.” *Id.*

The same is true here. In preparing his opinions, Dr. Nicholson assigned to Plaintiffs the scores of an average responding hospital. [Deposition Transcript of Sean Nicholson (“Nicholson Tr.”) 60:10-61:20, **Exhibit F**; Nicholson Rep. ¶ 66.] When asked why he did not use actual information about the Plaintiffs, Dr. Nicholson said that information was “not available.” [Nicholson Tr. 61:4] “I was not asked to conduct an analysis of Plaintiff Hospitals’ quality or measures that they’re using to manage their quality.” [*Id.* 41:2-5] Dr. Nicholson’s criticism of

LFG's surveys, therefore, ignores how Plaintiffs would have actually responded to those surveys. Instead, Dr. Nicholson imputed to the Plaintiff Hospitals the average grade of a "C," ignoring, among other things, their low one-star and two-star CMS ratings. [*Id.* 78:1-14]

Dr. Nicholson's decision to opine without information concerning Plaintiffs is the same deliberate ignorance that led to the exclusion of the proffered opinions in *Laumann* and *Sheffield*. Like the economists in those cases, Dr. Nicholson substituted assumptions for actual information about the Plaintiffs. *Laumann*, 117 F. Supp. 3d at 315. In the same way that the economist in *Sheffield* relied on "general statistics about average Americans," 2020 WL 1882906, at *4, Dr. Nicholson relied upon the scores of the average hospital. His opinions, therefore, are "untethered from tactual known factual data on the Plaintiff[s] in this case." *Id.* Consequently, Dr. Nicholson's opinions do not satisfy Rule 702.

Conclusion

WHEREFORE, Defendant The Leapfrog Group respectfully requests that the Court grant this Motion, exclude the testimony of Plaintiffs' expert witnesses, and grant such other and further relief as the Court deems proper.

GOOD FAITH CONFERENCE

Counsel for Defendant, The Leapfrog Group, has conferred with counsel for Plaintiffs in a good faith effort to resolve the issues raised in this motion and has been unable to do so.

Dated: November 12, 2025

Respectfully submitted,

WILSON ELSEER MOSKOWITZ
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on November 12, 2025, I electronically filed the foregoing with the Clerk of Court using the CM/ECF System which will send an electronic notification of such filings to all counsel of record in the Court's ECF filing system.

/s/ Jura Zibas
Attorney for Defendant

EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL CENTER,
INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

EXPERT REPORT OF THOMAS CHAKURDA

CONFIDENTIAL

I.	Introduction & Scope of Opinions.....	1
II.	Relevant Professional Background.....	1
III.	Summary of Opinions.....	3
IV.	Materials Relied Upon.....	4
V.	Independence of Opinions and Compensation	4
VI.	Background Regarding Hospital Brand Management	4
	A. Patients & Caregivers	6
	B. Referring Physicians	7
	C. Hospital Staff & Admitting Physicians.....	8
VII.	Negative TLG Grades Detract From a Hospital’s Brand.....	8
	A. Hospitals Must Expend Money to Capitalize on TLG Grades	10
	B. Negative TLG Grades Diminish a Hospital’s Brand	13
VIII.	TLG Encourages Private Payers to Tie Fee Reimbursement to TLG Grades	16

I, Thomas Chakurda, hereby declare under penalty of perjury that the following is true and correct:

I. Introduction & Scope of Opinions

1. I have been retained by Gibson, Dunn & Crutcher LLP, counsel for Good Samaritan Medical Center, Inc. (“Good Samaritan”), Delray Medical Center, Inc. (“Delray”), Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center (“Palm Beach Gardens”), St. Mary’s Medical Center, Inc. (“St. Mary’s”), and West Boca Medical Center, Inc. (“West Boca”) (collectively, “Plaintiffs”). I understand that Plaintiffs have filed a Complaint against The Leapfrog Group (“TLG”), an organization that publishes online grades for hospitals.¹ I understand that Plaintiffs stopped participating in TLG’s Hospital Survey, but continue to receive grades that are published on TLG’s website and in other outlets.² Plaintiffs allege, among other things, that TLG’s “D” and “F” grades have caused Plaintiffs harm to their reputations and goodwill.³

2. I have been asked to provide my opinions on the role of hospital rating systems, including TLG’s grades, in the brand management and marketing of hospitals, as well as to provide my opinions on the reputational impact of receiving negative TLG grades for hospitals. As discussed below, these opinions incorporate my decades of experience working in marketing and public relations for hospitals and the healthcare industry.

II. Relevant Professional Background

3. I have more than 40 years of marketing and public relations experience in the healthcare industry. I have held several roles as a senior executive in communications and marketing for healthcare systems including as Chief Marketing Officer at the Independence Health System, the third largest health system in Western Pennsylvania, the Vice President for Marketing and Communications at the Boca Raton Regional Hospital, and Vice President for Communications at the West Penn Allegheny Health System. I have a B.A. in communications and rhetoric from the University of Pittsburgh.

4. From 2009 to 2019, I served as the Vice President for Marketing and Communications at the Boca Raton Regional Hospital (formerly Boca Raton Community Hospital), where for over a decade I was part of a team of executives working to improve the

¹ Complaint and Demand for Jury Trial, Good Samaritan Medical Center, Inc., Delray Medical Center, Inc., Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center, St. Mary’s Medical Center, Inc., and West Boca Medical Center, Inc. v. The Leapfrog Group, Case No. 9:25-cv-80526, Dkt. 1 (April 30, 2025) (“Complaint”).

² Complaint, ¶¶2, 85–102.

³ Complaint, ¶116.

distressed financial situation of the institution. In this role, I oversaw and managed all hospital communications and marketing functions, including managing a major renaming and branding effort to reflect the evolution of the institution from a community hospital to an advanced tertiary medical center. During my time at Boca Raton Regional, the hospital earned recognition from U.S. News & World Report as a Top Ranked Regional Hospital in the South Florida metropolitan area and the highest ranked hospital in Palm Beach County.

5. Through my 10 years at Boca Raton Regional, I gained an extensive understanding of the healthcare industry in Southern Florida. In this role, together with my department and administration, I monitored our peer hospitals in the region and kept abreast of local market trends and research.

6. Most recently, and prior to my retirement in 2024, I served for five years as the Chief Marketing Officer at the Excelsa Health System, a three-hospital system located in Westmoreland County, Pennsylvania. In this role, I guided the communications functions as the Excelsa Health System merged with the Butler Health System to create Independence Health System, the third largest healthcare system in Western Pennsylvania.

7. Earlier in my career, I also served 10 years as the Vice President for Communications at the West Penn Allegheny Health System and an additional 10 years in a similar position at the Allegheny General Hospital and the hospital's parent corporation, Allegheny Health, Education and Research Foundation. In these roles I oversaw various communications functions including serving as the organization's spokesperson during the bankruptcy of Allegheny Health, Education and Research Foundation, and directing all internal and external communications for the System and its six hospitals including media relations, TV, radio, print and outdoor advertising, employee communications, and web communications. I also served as primary spokesperson and speech writer for the organization, overseeing the creation of all in-house advertising for the West Penn Allegheny Health System and the Allegheny General Hospital. Finally, I managed the name change and branding efforts for the newly-created West Penn Allegheny Health System after the bankruptcy of the Allegheny Health, Education and Research Foundation.

8. I also served as a Senior Account Executive at a public relations firm called Ketchum Public Relations, at that time the largest public relations firm in Pittsburgh, where I led healthcare client services.

9. Over the course of my career, I and the departments I have led, have earned over 100 awards for excellence in marketing and communications, including two American Hospital Association Touchstones. I have been named as a Public Relations Society of America

(Pittsburgh Chapter) “Renaissance Communicator of the Year”, as well as a Bismark “Advertising Executive of the Year” and “Public Relations Executive of the Year.” I am the winner of a Gold and Silver Telly Award for television spots I produced and also received the Comcast LAMP award for Best Regional Advertiser.

10. My extensive experience working in marketing and communications for hospitals is complemented by my experiences serving on boards and as a guest lecturer. I have served on the Boards of the Epilepsy Foundation of Western Pennsylvania, Leadership Pittsburgh, National Kidney Foundation, Juvenile Diabetes Research Foundation, Roberto Clemente Foundation and the Executive Committee of Westmoreland County Chamber of Commerce. For these organizations, brand and reputation management is an important strategic consideration. I have also been a guest lecturer at Carnegie Mellon University, Duquesne University and the University of Pittsburgh, presenting classes on public and media relations to journalism and communications students.

11. A full list of my experience and qualifications is provided in my CV which is attached as Exhibit A to this expert report.

III. Summary of Opinions

12. A hospital’s brand—which is fostered and publicized by hospital marketing—is critical to a hospital’s reputational and economic success. Hospitals must market their brands to many different stakeholders. Doctors who refer patients to hospitals are an important source for a hospital’s business, and therefore an important target audience for marketing. But, increasingly, patients and their caregivers research, identify, and select providers on their own, using the myriad of public sources available online and in the media. Hospitals thus also try to reach the public through marketing efforts. Moreover, hospital marketing builds goodwill that improves recruitment and retention of admitting doctors and hospital staff. As such, a strong hospital brand impacts all of the hospital’s stakeholders because it drives patients and caregivers to choose that hospital, and also increases patient referrals and doctor and staff recruitment and retention.

13. Although a hospital’s brand is multi-faceted, hospital ratings are a significant part of how a hospital is perceived in the community. TLG’s safety grades are among the more prominent of these hospital ratings. Hospitals who receive “A” or “B” TLG grades are willing to spend substantial money (up to tens of thousands of dollars) to publicize those grades in expectation of a commensurate boost to their brand. Conversely, hospitals who receive low TLG grades experience reputational harm to their brand. TLG takes steps to increase the

prominence of its grades and to encourage private payers to use its grades in rate negotiations for hospital fee reimbursements.

IV. Materials Relied Upon

14. The materials I considered in preparing this report are identified herein and/or in the list attached as Exhibit B. My analysis in this matter is ongoing and I reserve the right to supplement or amend my opinions if I receive additional information that warrants such a supplement or amendment or to respond to any opinions provided by experts retained by TLG.

V. Independence of Opinions and Compensation

15. I am being compensated at my standard billing rate of \$950 per hour. I have been assisted in this matter by staff of Cornerstone Research, who worked under my direction. None of my compensation in this matter is in any way contingent or based on the content of my opinion or the outcome of this or any other matter.

VI. Background Regarding Hospital Brand Management

16. The healthcare industry is highly competitive and hospitals are in constant competition with one another for patients. Hospitals face additional market pressures from alternative providers like ambulatory surgical centers, urgent-care facilities, and telemedicine providers that sometimes allow patients to bypass the hospital altogether. Hospitals further experience financial pressures from public and private payers, which can negatively impact revenue and operating budgets.

17. The economic success of a hospital is closely tied to its reputation in the community. Therefore, hospital systems invest significant resources in defining and maintaining their hospitals' brands. Hospital systems have dedicated marketing departments responsible for advertising, website and digital communications, competitive intelligence, patient outreach, and media relations, all with the aim of increasing and enhancing a hospital's brand. In addition, many hospitals work with external consultants who provide additional support in these areas.

18. In turn, a hospital's brand drives success in multiple areas, including the following "Three R's" for hospitals:

- Reputation: how the hospital is perceived in the community;
- Patient Response: how patients react to their experiences for care at that hospital, and their perceptions of its quality; and

- Recruitment and Retention: how well the hospital can attract and retain talented healthcare professionals.

19. Although marketing is a critical component for hospital success, most hospitals put most of their resources towards clinical priorities, improving patient outcomes, facilities, acquiring technology, and recruitment and retention of staff. This trend leaves hospital marketing departments with constrained budgets, forcing them to be highly selective in how marketing dollars are spent.

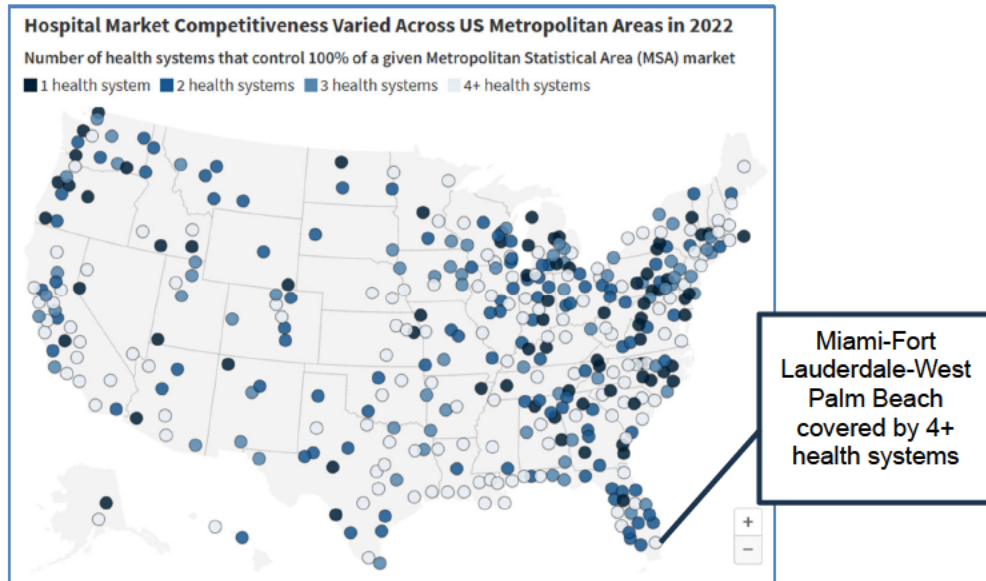
20. Nonetheless, hospitals experience pressure to spend more on marketing in more competitive geographical areas.⁴ South Florida and the Palm Beach area are a particularly competitive environment for hospitals. Based on my experience working in this area, patients are highly mobile between nearby cities (*e.g.*, Fort Lauderdale, Boca Raton, Miami) and many patients, including snowbirds who split their time between South Florida and another location, have the further capacity and means to seek healthcare from different geographic areas.⁵ Indeed, market studies have shown that the Palm Beach area is one of the most competitive markets in Florida.⁶ As shown on the map below, the Palm Beach area is one of the few in Florida to be covered by four or more hospital systems.⁷ These data reinforce the importance of marketing for hospitals located in the Palm Beach area, consistent with my experience at the Boca Raton Regional.

⁴ Huppertz *et al.*, *Hospital Advertising, Competition, and HCAHPS: Does It Pay to Advertise?*, HEALTH SERVS. RES., 52(4):1590-1611 (2016) (“Huppertz”), at pp. 1591–1592, 1596.

⁵ See, *e.g.*, Forbes, *Scores Of Americans Plan To ‘Snowbird’ This Winter* (Jan. 16, 2024), available at <https://www.forbes.com/sites/rogersands/2024/01/16/scores-of-americans-plan-to-snowbird-this-winter/> (“Hundreds of thousands of winter visitors spend 30-plus days in Florida each year.”); University of Florida Bureau of Economic and Business Research, *Florida Estimates of Population 2024* (Apr. 1, 2024), available at <https://edr.state.fl.us/content/population-demographics/data/Estimates2024.pdf> (“Many places in Florida have large numbers of temporary and/or seasonal residents during certain times of the year, making their peak populations larger than their resident populations.”); Lionswire / USA Today, *The Health Frontier: Medical providers expand in Palm Beach County with new clinics, hospitals* (Aug. 3, 2025), available at <https://lionswire.usatoday.com/story/business/real-estate/2025/08/03/health-care-companies-hospitals-patients-south-florida/83407463007/> (noting market for patients who “spent the winter in Palm Beach but still wanted access to NYU Langone care” in New York City); Godwin *et al.*, *One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2022*, KFF (October 1, 2024) and supporting data (“Godwin”) (grouping Miami, Fort Lauderdale, and West Palm Beach into a single geographic market); Guardado, *Competition in Hospital Markets, 2013-2021*, AMA POLICY RESEARCH PERSPECTIVES (March 2024) (“Guardado”) (grouping West Palm Beach, Boca Raton, and Boynton Beach area, which includes the Palm Beach area, into a single geographic market).

⁶ Godwin (finding Miami-Fort Lauderdale-West Palm Beach area had an HHI (concentration) lower than all other areas in Florida, and was one of the 10 lowest in the United States); Guardado (finding the West Palm Beach-Boca Raton-Boynton Beach area had a HHI that was one of the lowest among areas in Florida, and less than the weighted average HHI nationally); Lionswire / USA Today, *The Health Frontier: Medical providers expand in Palm Beach County with new clinics, hospitals* (Aug. 3, 2025), available at <https://lionswire.usatoday.com/story/business/real-estate/2025/08/03/health-care-companies-hospitals-patients-south-florida/83407463007/> (reporting that The Cleveland Clinic is opening a new 150 bed hospital in West Palm Beach while “The Hospital for Special Surgery, NYU Langone Health, Mass General Brigham and other players are vying for a piece of the pie in Palm Beach County, competing with Florida’s longtime healthcare providers”).

⁷ Godwin at Figure 2 (text annotation added).



21. Hospitals also must allocate their resources among many marketing channels.

These channels include:

- Direct-to-consumer advertising, such as print ads and television commercials and transit and outdoor advertising;
- Digital media, such as the hospital website and social media;
- Community sponsorships and philanthropy;
- Patient outreach through participation in a host of community events such as local health and wellness fairs; and
- Physician relations, which can include visits to referring physician offices or attendance at professional and networking events.

22. In addition, hospitals have many stakeholders—including patients, physicians, staff, and local community leaders—and must allocate their marketing efforts in order to effectively reach these different groups. As discussed below, each of these groups are marked by different interests, and therefore the marketing must be calibrated to each group separately.

A. Patients & Caregivers

23. The amount of hospital marketing has increased in recent years, mainly driven by a more informed population of patients and their caregivers, as well as a much more

aggressive and competitive environment in the healthcare industry.⁸ Patients and their families are much more participatory than ever before in selecting healthcare providers, in part driven by the myriad sources of information that allow patients and caregivers to do their own research.⁹

24. However, as hospitals increase their marketing and younger caregivers take an ever-increasing role in decision-making for parents and older relatives, hospitals increasingly target new patients and caregivers through advertisements on television or radio and in print. Marketing teams also work to increase unpaid marketing through social media and public relations, which includes work to generate positive press in the media because stories in independent media are often more meaningful to patients because they are not directly generated by the hospital and perceived to be more objective.¹⁰

B. Referring Physicians

25. Physicians in private practice who refer patients to hospitals for in-hospital procedures are also an important target audience for hospital marketing. Referring physicians are highly influential in choosing where to refer patients, and referral relationships between hospitals and doctors are exceedingly important.¹¹

26. Hospital marketing teams include physician liaisons who foster these relationships. These physician liaisons remain in regular contact with local physicians, ensuring that they are aware of the hospital's services, capabilities, and accolades. They also receive feedback from the physicians that can lead directly to hospital improvements to garner additional utilization for the hospital.

⁸ Huppertz at pp. 1591–1592 (“Hospital administrators have continued to spend funds on advertising, arguing that they must build and hold market share to survive in an increasingly competitive marketplace. ... Patient involvement in choosing providers has increased, motivating hospital administrators to use advertising to communicate with patients directly.”); NY Times Licensing, 29 *Healthcare Marketing Statistics to Know for 2024*, available at <https://nytlicensing.com/latest/trends/healthcare-marketing-stats/> (“Despite the slow adoption, healthcare companies are increasingly seeing the importance of content and are willing to put more money towards content, advertising, and lead generation in the coming years. ... The IMARC Group forecasts that U.S. healthcare advertising will grow from \$22.4 billion in 2022 to \$29.2 billion in 2028.”).

⁹ Purcarea, *The impact of marketing strategies in healthcare systems*, J. MED. & LIFE, 12(2):93–96 (2019) (“Purcarea”), at pp. 93, 95–96 (“[I]t is important to understand today’s medical consumer who prefers to look for medical information online, where he also has a wealth of healthcare services, healthcare providers, reviews from patients who contacted the provider, etc.”).

¹⁰ Purcarea at p. 94 (“Although the consumer typically receives most of the information about a product through the commercial media. The most important information comes from recommendations or from publicly available independent authorities. The two categories of sources provide complementary functions; commercial media – informs, while personal or expert sources legitimize or potentiate the evaluation process.”), pp. 95–96 (“At present, digital content helps build positive brand impressions. The use of new digital marketing strategies is essential to maximize the efficiency of marketing expenses and generate higher return rates.”).

¹¹ Purcarea at p. 93 (“[T]he beneficiary may not be the target of the marketing campaign, the physician being the one who decides what, where, when, and how much will be provided for a particular service. The decision-maker may be the doctor, the health plan representative, a family member.”).

27. Referring physicians are very responsive to their patient's preferences. If a physician refers a patient to a hospital, and the patient reports a bad experience, the physician can be reluctant to refer additional patients. Similarly, if a hospital has a negative reputation in the community, a physician can be reluctant to make referrals unless there is a significant countervailing reason to select that hospital.

C. Hospital Staff & Admitting Physicians

28. The doctors who provide care at hospitals also make choices. These doctors must seek and obtain admitting privileges at the hospital where they want to provide care, and are very aware that their reputations will be tied to the hospital at which they have admitting privileges. Some doctors choose to obtain admitting privileges at more than one hospital, either within the same hospital system or different hospital systems.

29. In addition, hospitals depend on recruiting high-quality support staff for all aspects of care, including nurses, pharmacists, administrators, receptionists, technicians, environmental service workers, and food service workers.

30. Hospital marketing is designed to build and convey internally and externally an environment of success and quality of care, which makes admitting doctors and hospital staff proud to be affiliated with the hospital. To attract and retain the best talent, hospital marketing teams are committed to fostering an intrinsic pride of working with a stellar organization. Having a strong hospital brand that is known within the community is a core aspect of fostering this pride. Hospitals want their doctors and staff to be proud of their hospital brand and committed to protecting it, and that shared pride encourages a continued focus on improving patient care.

VII. Negative TLG Grades Detract From a Hospital's Brand

31. Hospital rating systems impact a hospital's brand and reputation both positively and negatively. These ratings can impact how the hospital is perceived by patients and providers, and in turn, drive patients and providers to choose one hospital over another.

32. There has been a proliferation of different hospital rating systems, each of which has its own methodology and goals. Some hospital rating systems are government-mandated. For example, the U.S. Department of Health and Human Services requires hospitals to report data to the Centers for Medicare & Medicaid Services ("CMS"), and this CMS data is published in raw form and also compiled into patient-facing Hospital Quality Star Ratings on CMS's

CareCompare website.¹² Some state and local governments also require hospitals to report data.

33. Third-party organizations also rate hospitals, including TLG, U.S. News & World Report, Healthgrades, and Newsweek. For these ratings, participation is not mandated (unlike CMS), but there is strong institutional pressure to participate. As the public awareness and prevalence of these ratings increases, the pressure to participate increases, or else hospitals risk falling behind their competitors.¹³ “As ratings multiply, more and more hospitals have something they can boast about.”¹⁴

34. Knowing that these ratings from third-party organizations are critical marketing tools, most hospitals prominently display them on their websites and around their facilities (e.g., on bulletin boards and welcome banners within the hospital facilities). For example, the Plaintiffs prominently list awards from U.S. News & World Report and Healthgrades, alongside those from many other organizations.¹⁵ One of the Plaintiffs’ competitors, Jupiter Medical Center, also lists awards from these organizations, as well as its “A” grade from TLG, prominently on its own website.¹⁶

35. It is well-known that these types of hospital ratings can provide market differentiation between hospitals, which helps drive patients to choose one hospital over another. For example, patients may not understand or have insight into what makes a hospital a leader in treating strokes or heart failure, so are willing to put their trust in online rankings that tout a hospital as “the best” or “excellent” in these areas.¹⁷ Therefore, from a marketing perspective, hospital ratings are a key element of shaping public perception of a hospital and sustaining or creating increased utilization of that hospital, and therefore obtaining and improving hospital ratings is a central goal for hospitals.¹⁸

¹² Medicare.gov, *Find & compare providers near you*, “Hospitals” Care Compare search page, <https://www.medicare.gov/care-compare/?redirect=true&providerType=Hospital>

¹³ E.g., PBS News, *How Good Is Your Hospital? Depends Who You Ask* (Mar. 18, 2013), <https://www.pbs.org/newshour/health/how-good-is-your-hospital-depends-who-you-ask>

¹⁴ PBS News, *How Good Is Your Hospital? Depends Who You Ask* (Mar. 18, 2013), <https://www.pbs.org/newshour/health/how-good-is-your-hospital-depends-who-you-ask>

¹⁵ Palm Beach Health Network, *Awards and Distinctions*, <https://www.palmbeachhealthnetwork.com/about/awards-distinctions>

¹⁶ Jupiter Medical Center, *Awards & Recognition*, <https://www.jupitermed.com/about/awards-recognition/>

¹⁷ Ellis *et al.*, *National Evaluation of Patient Preferences in Selecting Hospitals and Healthcare Providers*, PATIENT-CENTERED CARE, 58:867–873 (2020) (“Ellis”), at Tables 1 and 2 (finding 53.4% of consumers researched healthcare on Google and 21.1% used online rankings; 61.9% report that reputation of the hospital is “Important” or “Very Important”).

¹⁸ Hibbard *et al.*, *Hospital Performance Reports: Impact on Quality, Market Share, and Reputation*, HEALTH AFFAIRS, 24(4):1150–1160 (2005) (“Hibbard”) (“If a hospital’s reputation is affected, it may eventually experience market share declines via consumer choice, purchaser choice, or physician referral. A declining hospital reputation may pose other challenges such as recruiting and retaining qualified physicians and nurses. Similarly, both market share and reputation can affect a hospital’s ability to maintain legitimacy and professional standing.”).

36. Given the importance of hospital ratings to brand management, hospital administrators must dedicate significant resources towards obtaining, sustaining, or improving these ratings. As one chief clinical officer said: “Even though there’s not a hospital executive who won’t tell you that they have a great deal of skepticism about a lot of the methodology, there’s not one who will tell you they don’t want to be on the lists.”¹⁹ However, hospitals in general and marketing departments in particular only have so much budget to put towards these efforts given the economic constraints of the healthcare industry. Therefore, hospital administrators are constantly weighing (a) the prominence, influence, and validity of the various hospital ratings systems against (b) the expense and operational burden of participating in those rating systems.

A. Hospitals Must Expend Money to Capitalize on TLG Grades

37. As discussed above, hospitals are required to report many metrics to federal, state, and local agencies, including CMS. To participate in TLG, TLG requires hospitals to complete a lengthy “Leapfrog Hospital Survey.” The efforts to participate in the Leapfrog Hospital Survey are on top of mandatory reporting obligations. Moreover, there is a general lack of harmony and standardization among the various third-party rating organizations, leading to additional expenditure and effort.²⁰

38. Hospitals must pay a TLG licensing fee to promote their grade in marketing efforts.²¹ Thus, Leapfrog “not only encourage[s] this but also profit[s] from it by charging licensing fees to hospitals that want to advertise their awards.”²² If a hospital does not pay the licensing fee, they can only issue a plain-text press release and internal announcement, without using any TLG graphics or logos.²³ TLG has a separate licensing arm that encourages hospitals to pay to license and promote the TLG grade.²⁴ The current price for a license ranges from

¹⁹ PBS News, *How Good Is Your Hospital? Depends Who You Ask* (Mar. 18, 2013), <https://www.pbs.org/newshour/health/how-good-is-your-hospital-depends-who-you-ask>

²⁰ Hwang *et al.*, *Finding Order in Chaos: A Review of Hospital Ratings*, AM. J. MED. QUALITY, 31(2):147–155 (2016) (“Hwang”), at p. 147 (“The information on the quality of hospital care is chaotic and inconsistent at best.”); “These organizations select different sets of quality measurements, either with existing data available in the public domain or through proprietary data collection.”); Fierce Healthcare, *Rating the raters? Hospital experts turn tables and critique quality comparison sites* (Aug. 14, 2019), available at <https://www.fiercehealthcare.com/hospitals-health-systems/rating-raters-hospital-experts-turn-tables-and-critique-quality-comparison> (noting “Each rating system had unique weaknesses that led to potential misclassification of hospital performance, ranging from inclusion of flawed measures, use of proprietary data that are not validated, and methodological decisions,” and reporting that “The lowest grades went to Leapfrog, to which they gave a C-, and to Healthgrades, which got a D+.”).

²¹ The Leapfrog Group, *How to License Your Designated Logo*, <https://leapfroglicensing.org/promote-your-award>

²² PBS News, *How Good Is Your Hospital? Depends Who You Ask* (Mar. 18, 2013), <https://www.pbs.org/newshour/health/how-good-is-your-hospital-depends-who-you-ask>

²³ The Leapfrog Group, *How to License Your Designated Logo*, <https://leapfroglicensing.org/promote-your-award>

²⁴ The Leapfrog Group, *Recognition from Leapfrog Is Significant. And Sharing Your News is Essential!*, <https://leapfroglicensing.org/>

\$6,700 to \$29,900, depending on the size of the hospital.²⁵ The hospital must pay this license fee again for each subsequent TLG grade, up to two times per year.

39. Purchasing a TLG license allows a hospital to “[p]romote and co-brand using Leapfrog’s logo,” and TLG encourages hospitals to do so on:

- “Websites, videos, press releases and social media”
- “TV, radio and print advertisements”
- “Billboards, signage, banners and balloons”
- “Flyers, brochures, newsletters and email signatures”²⁶

40. The TLG license also comes with a media toolkit including “[h]igh resolution logos in various formats,” “[p]rint and digital templates for advertisements that you can easily customize for your facility, with multiple messaging options to choose from,” and “[a] Leapfrog ‘A’ Grade widget to embed on your website, with dynamic code that automatically updates if you achieve your designation again in a subsequent cycle.”²⁷

41. TLG’s website provides numerous samples of how hospitals have promoted their TLG grades using their license and media toolkit on social media and in print.²⁸ TLG further encourages hospitals to place its grades on billboards or other advertisements, like the below:



²⁵ The Leapfrog Group, *Leapfrog Designated Logo License – Letter of Agreement* (Spring 2025), <https://leapfroglicensing.org/sites/default/files/2025-03/Spring%202025%20Accolade%20Letter%20of%20Agreement%20%26%20Exhibit%20A.pdf>

²⁶ The Leapfrog Group, *How to License Your Designated Logo*, <https://leapfroglicensing.org/promote-your-award>

²⁷ The Leapfrog Group, *You Reached Leapfrog’s Top Grade. Let’s Celebrate Together!*, <https://leapfroglicensing.org/awards/hospital-safety-grade>

²⁸ The Leapfrog Group, *See How Hospitals and Surgery Centers Are Sharing Their News*, filtered to “Hospital Safety Grade,” <https://leapfroglicensing.org/sample-gallery>

42. TLG further provides the following image showing how Plaintiffs' competitor Jupiter Medical Center prominently displays the TLG logo on-premises²⁹:



43. In my experience, the decision to participate in, and then subsequently license, TLG grades is a joint decision made at the highest levels of hospital management. Many factors go into this decision, including whether the hospital's competitors participate, whether the hospital expects an upgrade to their TLG grade, the cachet of TLG, and budget constraints. TLG tracks its revenue from licensing TLG grades, and also attempts to capture information on why hospitals choose *not* to license the grades.³⁰ In Fall 2024, TLG made more than 8,800 calls to sell licenses, resulting 174 safety grade (HSG) licenses and more than \$1.5 million in revenue.³¹ Of the hospitals who declined a license in Fall 2024, 28% reported declining for financial reasons (20% due to "Price," 4% because "Marketing budget already allocated," and 4% because "Hospital doesn't have a marketing budget").³² No declining hospitals provided a reason indicating that the TLG grades are inconsequential for consumers.³³

44. As discussed above, the decision to pay TLG's license fee enables the hospital to place TLG's logo across all media, including television ads, print media, social media, and the hospital's website and provides hospitals with a media toolkit to do so. Hospitals would

²⁹ The Leapfrog Group, *How to License Your Designated Logo*, <https://leapfroglicensing.org/promote-your-award>

³⁰ LEAPFROG00143080–LEAPFROG00143108; LEAPFROG00510740–LEAPFROG00510770.

³¹ LEAPFROG00510740–LEAPFROG00510770, at LEAPFROG00510742, LEAPFROG00510746, LEAPFROG00510758.

³² LEAPFROG00510740–LEAPFROG00510770, at LEAPFROG00510768; *see also* LEAPFROG00143080–LEAPFROG00143108, at LEAPFROG00143107 (Spring 2024 data showing 8% of declining hospitals cite "Price," 15% cite "Marketing budget already allocated," 1% cite "Hospital doesn't have a marketing budget," and 4% cite "Unable to get approved for use in hospital marketing").

³³ LEAPFROG00510740–LEAPFROG00510770, at LEAPFROG00510768; *see also* LEAPFROG00143080–LEAPFROG00143108, at LEAPFROG00143107 (Spring 2024 data showing only 1% say "Consumers don't understand hospital ratings").

not make the expenditure to license their TLG grade if they did not think it would have a corresponding positive impact on the hospital's brand and patient utilization.

B. Negative TLG Grades Diminish a Hospital's Brand

45. While positive TLG grades provide a marketing boost for hospitals, negative TLG grades can significantly damage a hospital's reputation. Based on my experience, the detrimental impact of an "F" grade is magnified as compared to the positive impact of an "A."³⁴ Receiving an "F" grade leaves a strong and long-lasting impression in the community.³⁵ TLG touts that: "Recognition from Leapfrog is big news ... *Media outlets know this and regularly cover our designation announcements.*"³⁶

46. Once stakeholders are aware of the "F" grade, it then harms the hospital's brand, impacting all of the three R's discussed above (reputation, patient response, and recruiting/retention). A patient or their caregiver who is researching local hospitals is likely to come across TLG grades, either in a hospital's promotional materials, in the media, or through the TLG website, which is the top result on Google for "hospital safety rankings."³⁷

47. TLG takes steps to amplify this impression by publicizing grades and promoting them in the media.³⁸ Before each biannual release, TLG engages in a months-long effort to place stories about its grades in press, television, radio, and digital media.³⁹ Beginning four months before each data release, TLG meets every two weeks internally and each month with

³⁴ E.g., Cutler *et al.*, *The Role of Information in Medical Markets: An Analysis of Publicly Reported Outcomes in Cardiac Surgery*, AM. ECONOMIC REV., 94(2):342–346 (2004) ("Cutler"), at p. 345 ("In contrast to their impact on low-quality hospitals, the reports do not seem to increase future volume for those facilities receiving low-mortality flags."); Wang *et al.*, *Do bad report cards have consequences? Impacts of publicly reported provider quality information on the CABG market in Pennsylvania*, J. HEALTH ECONOMICS, 30:392–407 (2011) ("Wang") (finding that cardiac care providers that are poorer performer or are unrated experience a reduction in patient volume but also finding no effect on patient volumes for more highly rated surgeons or hospitals).

³⁵ E.g., Chicago Booth Review, *Why Negative News Sticks in Our Minds* (Nov. 17, 2022), available at <https://www.chicagobooth.edu/review/why-negative-news-sticks-our-minds> ("Since ancient times, people have been learning to steer clear of dangerous situations, and our knowledge of potential risks has grown as we've evolved. According to standard psychological theories, this is how we have come to pay close attention to negative information—closer attention, in fact, than we do to positive information."); VeryWellMind, *What Is the Negativity Bias* (Nov. 13, 2023), available at <https://www.verywellmind.com/negative-bias-4589618> ("In almost any interaction, we are more likely to notice negative things and later remember them more vividly."; "We tend to ... Make decisions based on negative information more than positive data."); Trussler *et al.*, *Consumer Demand for Cynical and Negative News Frames*, INT'L J. PRESS/POLITICS, 19(3):360–379 (2014) ("Trussler"), at pp. 362–364, 373–374 (describing trends towards "strategic and negative" coverage, which can be explained by media and consumer bias towards negative framings).

³⁶ The Leapfrog Group, *Recognition from Leapfrog Is Significant. And Sharing Your News is Essential!*, <https://leapfroglicensing.org/> (emphasis added).

³⁷ Complaint, ¶77; May 13, 2025 Declaration of Jerad Hanlon and exhibits thereto ("Hanlon Declaration"), ¶19; see also Ellis, at Tables 1 and 2.

³⁸ Leapfrog Press Release, *Leapfrog's Spring 2025 Safety Grades Are In — New Trend Data Shows One in Eight Hospitals Sustained an "A" for More Than Two Years* (May 1, 2025), available at <https://www.leapfroggroup.org/news-events/leapfrog%E2%80%99s-spring-2025-safety-grades-are-%E2%80%94new-trend-data-shows-one-eight-hospitals>; Leapfrog Press Release, *Fall 2024 Leapfrog Hospital Safety Grade Shows Significant Progress in Patient Safety Nationwide* (Nov. 15, 2024), available at <https://www.leapfroggroup.org/news-events/fall-2024-leapfrog-hospital-safety-grade-shows-significant-progress-patient-safety>

³⁹ LEAPFROG00267896–LEAPFROG00267911, at LEAPFROG00267899–900.

its public relations consultant, CURA to plan these efforts.⁴⁰ TLG “record[s] radio spots” for both national and state-wide broadcasts, and also creates “TV packages to increase [TLG’s] TV media coverage.”⁴¹ TLG creates a social media plan, including graphics with quotes from its CEO Leah Binder, state rankings, and data trends, and also works to “[r]etweet or post [Hospital Safety Grade] coverage from [n]ews outlets.”⁴² TLG also embargoes its grades with the press “at least one week before the public launch date” and uses CURA to send “pitches” to media outlets.⁴³

48. TLG closely monitors the media impact of its TLG grades to ensure a broad reach across all channels. On November 15, 2024—the day TLG released its Fall 2024 grades—TLG registered 174 total pieces of digital coverage, 3 print articles, 26 television placements, and 7 radio placements.⁴⁴ In the week following its Fall 2024 grades, TLG created a Media Coverage Report showing that its grades appeared in 722 online articles, 160 print placements, 205 television placements, and 34 radio placements.⁴⁵ TLG highlighted that Florida had the highest number of articles covering the Fall 2024 grades that week (73 articles) and that “Leapfrog receives the most coverage from the southeast region.”⁴⁶ Similarly, TLG’s Media Coverage Report for the week following its Spring 2025 grades documented 774 online articles, 127 print placements, 151 television placements, and 100 radio placements.⁴⁷ Florida had the second-highest coverage, with 46 articles with the “South (SC, NC, VA, FL, TX)” being one of the “major coverage drivers.”⁴⁸

49. As it relates specifically to Plaintiffs’ hospitals, TLG’s “D” and “F” grades received material publicity in local, national, and global media outlets, including the UK’s Daily Mail, the Miami Herald, the local PBS/NPR affiliate WLRN, and local radio station 97X,

⁴⁰ LEAPFROG00267896–LEAPFROG00267911, at LEAPFROG00267901.

⁴¹ LEAPFROG00267896–LEAPFROG00267911, at LEAPFROG00267905.

⁴² LEAPFROG00267896–LEAPFROG00267911, at LEAPFROG00267909.

⁴³ LEAPFROG00267896–LEAPFROG00267911, at LEAPFROG00267903; *see also* LEAPFROG00387902 (CURA invoice documenting its October 2024 efforts to, among other things, “Develop[] strategic media angles,” “Review[] the regional and national press releases,” and coordinate outreach to New York Magazine, The New York Times, Patch, TapInfo, and Spectrum).

⁴⁴ LEAPFROG00323940–LEAPFROG00323941

⁴⁵ LEAPFROG00328568–LEAPFROG00328573, at LEAPFROG00328568.

⁴⁶ LEAPFROG00328568–LEAPFROG00328573, at LEAPFROG00328569–70.

⁴⁷ LEAPFROG00241845–LEAPFROG00241851, at LEAPFROG00241845.

⁴⁸ LEAPFROG00241845–LEAPFROG00241851, at LEAPFROG00241846–47.

as well as in trade press like Stet News and Becker's Hospital Review.⁴⁹ Patients and their caregivers become suspicious or fearful of hospitals with an "F" grade, and the impact can spread via social media, online reviews, and word of mouth.⁵⁰ For example, TLG's grades for the Delray, Good Samaritan, Palm Beach Gardens, and West Boca hospitals are featured in videos on TikTok and Instagram that received over 1 million views and tens of thousands of "likes" as of the date of this report, and which describe these hospitals as among the five worst hospitals in Florida.⁵¹ The dissemination of TLG's grades online and through social media reaches a wide audience of patients and caregivers and makes it difficult for Plaintiffs to provide their explanations or clarifications. Moreover, TLG releases its grades twice per year, which renews the publicity every six months.

50. I have reviewed documents and statements produced by Plaintiffs showing that their management and marketing employees received requests for comment from the media and were concerned about the reputational impact of TLG's grades following the Fall 2024 release.⁵² Plaintiffs engaged in crisis management efforts to counteract statements about TLG's grades in the media, for example, drafting multiple press releases.⁵³ This information confirms that the reputation of Plaintiffs' hospitals was impacted by TLG's "D" and "F" grades, consistent with my experience and the general expectations in the healthcare industry.

51. Referring physicians can be reluctant to refer patients to a hospital with an "F" grade, knowing that the patients may discover these grades online. TLG itself promotes that

⁴⁹ See, e.g., Becker's Hospital Review, *Where are Leapfrog's 13 'F' hospitals?*, (Nov. 15, 2024), available at <https://www.beckershospitalreview.com/rankings-and-ratings/where-are-leapfrogs-14-f-hospitals/>; 97X, 3 *Florida Hospitals Receive 'F' Grades for Patient Safety* (Nov. 26, 2014), available at <https://97x.com/3-florida-hospitals-receive-f-grades-for-patient-safety/>; Stet News, *Tenet hospitals at bottom of local safety grades* (Dec. 9, 2024), available at <https://stetnews.org/2024/12/09/tenet-hospitals-at-bottom-of-local-safety-grades/>; WLRN, *Five of Palm Beach County's largest hospitals at bottom of local safety grades* (Dec. 11, 2024), available at <https://www.wlrn.org/health/2024-12-11/tenet-hospitals-palm-beach-county-safety>; MailOnline, *Every acute care hospital in America RANKED* (Jan. 6, 2025), available at <https://www.dailymail.co.uk/health/article-14256459/acute-care-hospital-america-ranked-dangerous-interactive-map.html>; Miami Herald, *What are the best and worst South Florida hospitals for patient safety? See the rankings* (Jan. 16, 2025), available at <https://www.miamiherald.com/news/health-care/article297048999.html>

⁵⁰ See, e.g., Medical Economics, *Online reviews are becoming more important to patients in choosing their care: How to manage your online reputation in health care* (May 2, 2023), available at <https://www.medicaleconomics.com/view/online-reviews-are-becoming-more-important-to-patients-in-choosing-their-care-how-to-manage-your-online-reputation-in-health-care> ("about 94% of patients today use online reviews to evaluate providers, clearly indicating the massive role reviews play in shaping the reputation — and continued success — of any health care organization"); Cutler, at p. 345 (finding significant loss in patient volume following high mortality ratings).

⁵¹ E.g., TikTok, account usamap55 (July 10, 2025), <https://www.tiktok.com/@usamap55/video/7525460573430107405>; Instagram, account ptrssnzwa (July 17, 2025), <https://www.instagram.com/reel/DMOVYTMOXLS/>; Instagram, account cleefcleef (July 11, 2025), https://www.instagram.com/reel/DL_RjdDNoSG/; Instagram, account official_jformula (July 13, 2025), <https://www.instagram.com/reel/DMCLxOGAthi/>

⁵² PBHN000002066–PBHN000002070; PBHN000002072–PBHN000002075; PBHN000002076–PBHN000002078; PBHN000002095–PBHN000002102; May 13, 2025 Declaration of Erik Cazares and exhibits thereto ("Cazares Declaration"), ¶¶24–25; Hanlon Declaration, ¶25; May 14, 2025 Declaration of Heather Havericak and exhibits thereto ("Havericak Declaration"), ¶26; May 13, 2025 Declaration of Cynthia McCauley and exhibits thereto ("McCauley Declaration"), ¶¶36–37; May 14, 2025 Declaration of Sheri Montgomery and exhibits thereto ("Montgomery Declaration"), ¶¶26–27.

⁵³ PBHN000002618; PBHN000002607–PBHN000002610; PBHN000002611; PBHN000002612–PBHN000002613; PBHN000002614; PBHN000002604–PBHN000002606; PBHN000002615–PBHN000002617.

“[r]ecognition from Leapfrog [i]s [s]ignificant.”⁵⁴ TLG further explains that “Leapfrog designations are highly beneficial to your patients and employees, so it’s important to let your community know about your recognition.”⁵⁵ The Plaintiffs’ hospitals in fact received feedback from doctors, other personnel, and community members urging Plaintiffs to participate in TLG in the future because of reports that patients avoided Plaintiffs’ hospitals following release of the Fall 2024 TLG grades.⁵⁶ Again, this demonstrates that TLG’s grades reach referring physicians and impact the conversations between those physicians and their patients, consistent with my experience and the general expectations in the healthcare industry.

52. TLG grades also have a substantial impact on recruitment and retention. For hospital staff and admitting physicians, TLG promotes that its grades should be used for “morale-building and open appreciation,” to “increase[e] productivity and loyalty,” and to “attract healthcare professionals already aligned with your mission.”⁵⁷ TLG thus recognizes that its scores are significant to employees and physicians already affiliated with hospitals, and that negative TLG scores can impact hiring and retention.

VIII. TLG Encourages Private Payers to Tie Fee Reimbursement to TLG Grades

53. Private payers are also an important constituency for hospitals. Private payers negotiate with each hospital system to decide the reimbursement rates for hospital services. TLG directly promotes its grades to private payers, encouraging them to offer “contract incentives” to hospitals that achieve higher grades.⁵⁸ TLG touts that: “One regional health plan uses Leapfrog data to supplement Medicare data in their pay-for-performance program, with Leapfrog Hospital Survey data accounting for 50% of their reimbursement strategy.”⁵⁹ Until recently, TLG’s website encouraged health plans to “[i]ntegrate” the TLG grade “into

⁵⁴ The Leapfrog Group, *Recognition from Leapfrog Is Significant. And Sharing Your News is Essential!*, <https://leapfroglicensing.org/>

⁵⁵ The Leapfrog Group, *How to License Your Designated Logo*, <https://leapfroglicensing.org/promote-your-award>

⁵⁶ PBHN000002071; PBHN000002090–PBHN000002094; PBHN000002103; Cazares Declaration, ¶¶24, 26; Hanlon Declaration, ¶25; Haverick Declaration, ¶¶26–28; McCauley Declaration, ¶¶36–37; Montgomery Declaration, ¶¶27–28; *see also* Palm Beach Gardens’ Response to First Set of Interrogatories (July 25, 2025), No. 23; West Boca’s Response to First Set of Interrogatories (July 25, 2025), No. 12; Delray’s Response to First Set of Interrogatories (July 25, 2025), No. 22; Good Samaritan’s Response to First Set of Interrogatories (July 25, 2025), No. 22; St. Mary’s Response to First Set of Interrogatories (July 25, 2025), No. 22.

⁵⁷ The Leapfrog Group, *How to License Your Designated Logo*, <https://leapfroglicensing.org/promote-your-award>; The Leapfrog Group, *You Reached Leapfrog’s Top Grade. Let’s Celebrate Together!*, <https://leapfroglicensing.org/awards/hospital-safety-grade>

⁵⁸ The Leapfrog Group, *Frequently Asked Questions About The Leapfrog Hospital Safety Grade*, <https://www.hospitalsafetygrade.org/frequently-asked-questions> (“employers can structure the way they pay for health care to reward excellence in safety. For instance, higher graded hospitals might earn contract incentives”); *see also* <https://www.leapfroggroup.org/news-events/hidden-surcharge-americans-pay-hospital-errors> (“Purchasers should also use the Hidden Surcharge Calculator in contract negotiations with their health plan provider, as well as in conversations with their benefits consultant and local business coalition on health.”).

⁵⁹ The Leapfrog Group, *Why Leapfrog*, <https://www.leapfroggroup.org/data-users/why-leapfrog>

existing pay-for-performance programs,”⁶⁰ and TLG continues to offer a “Value-Based Purchasing Program” to encourage payers to “set benchmarks for financial awards or incentives, such as awarding the highest reimbursement rate to hospitals scoring in the top decile” on scores compiled from the TLG Hospital Survey.⁶¹

54. TLG also recruits “Regional Leaders” who are “[e]mployers and purchasers” that “use their collective leverage to request that hospitals and ASCs [ambulatory surgery centers] participate in the Leapfrog Surveys.”⁶² The Regional Leader for Florida is the Florida Alliance for Healthcare Value, whose membership includes at least 80 Florida businesses and public sector organizations.⁶³ By engaging with payers through its Regional Leaders, TLG amplifies the impact on its grades on this important constituency. TLG provides a toolkit that instructs its Regional Leaders, like the Florida Alliance for Healthcare Value, to “[e]ncourage your members to use Leapfrog for payment policies, tiering, and public reporting.”⁶⁴ TLG further tells its Regional Leaders to “[e]ngage employers with purchasing power to influence hospital decision-making based on Hospital Survey participation,” and to also “[m]eet with local media” and “[d]iscuss one or more items in the survey that might make a good story.”⁶⁵ TLG provides its Regional Leaders with template letters stressing “how payors are planning to use or are currently using Leapfrog’s Survey data (e.g., value-based purchasing program, high performance network determination, consumer directory).”⁶⁶

55. As such, in conjunction with its efforts to secure media placements discussed above, TLG also takes steps to expand the reach of the TLG grades to payers who can exert additional pressure on hospitals to participate in TLG’s Hospital Survey.

* * * * *

56. I understand that TLG has the opportunity to present opinions from one or more experts in this matter and that the parties are continuing to produce documents and evidence in this case. For example, I have been informed that TLG produced more than 250,000 documents in the four days before this report was due, including 93,000 documents on Sunday, August 3

⁶⁰ Wayback Machine archive of The Leapfrog Group, *How Health Plans Can Use Leapfrog Data*, <https://web.archive.org/web/20250516201656/https://www.leapfroggroup.org/data-users/how-health-plans-can-use-leapfrog-data> (archive from May 16, 2025). As of the date of this report, the webpage at <https://www.leapfroggroup.org/data-users/how-health-plans-can-use-leapfrog-data> is password-protected. However, I have been informed that the webpage was not password protected—and thus available publicly—as recently as July 31, 2025.

⁶¹ The Leapfrog Group, *Leapfrog Value-Based Purchasing Program*, <https://www.leapfroggroup.org/VBP-Program>

⁶² The Leapfrog Group, *Our Local Footprint*, <https://www.leapfroggroup.org/regional-leaders>

⁶³ The Leapfrog Group, *Florida Alliance for Healthcare Value*, <https://www.leapfroggroup.org/regional-leaders/florida-alliance-healthcare-value>; Florida Alliance for Healthcare Value, *Employer Members*, <https://flhealthvalue.org/about/employer-members/>

⁶⁴ LEAPFROG00140378–LEAPFROG00140423, at LEAPFROG00140382.

⁶⁵ LEAPFROG00140378–LEAPFROG00140423, at LEAPFROG00140384.

⁶⁶ LEAPFROG00140378–LEAPFROG00140423, at LEAPFROG00140394–408.

and 156,000 documents on Wednesday, August 6. As I have not yet had the opportunity to meaningfully review these documents, I reserve the right to adjust my opinions based on my review of documents recently produced or that will be produced in this litigation. I also reserve the right to supplement my analysis and conclusions set forth in this report to respond to the opinions of TLG's expert(s) or based upon any additional discovery performed or disclosed by the parties.

Executed this 7th day of August, 2025

A handwritten signature in cursive script, appearing to read "Thomas G. Chakurda".

Thomas Chakurda

ELEVENCANTERBURY**THOMAS CHAKURDA
PENNSYLVANIA****EXPERIENCE****EXCELA HEALTH/INDEPENDENCE HEALTH SYSTEM****2019 – 2024*****Chief Marketing and Communications Officer, Greensburg, PA***

- Executive leadership for all system/hospital communications functions, both internal and external
 - Included were print, digital, television, radio, outdoor and transit platforms
- In addition, was responsible for development and implementation of collateral materials for myriad lay and professional constituencies
- Served as primary spokesperson and speech writer for the system and its hospitals
- Functioned as Creative Director for advertising and communications vehicles, which included the development and application of all television and print concepts
 - Campaigns were developed in-house with no outside agency support – resulting in substantial financial savings for the organization
- Department expenses maintained at budget throughout tenure
- Executive oversight of redesign of two new websites for the organization
- Played an integral role in the development of new system nomenclature and resultant rebranding initiatives that included brand identity, system launch campaign, campus signage and a spectrum of support materials

BOCA RATON REGIONAL HOSPITAL**2009 – 2019*****Vice President, Marketing and Communications, Boca Raton, FL***

- Oversight and management of all hospital communication and marketing functions, including print, television, radio, and web advertising; employee and clinical staff communications, collateral materials for multiple lay and professional constituencies, web redesign, media relations, speech writing, Hospital video projects and campus signage design
- Served as Creative Director of all advertising and communication vehicles produced in-house with no agency support, including the production of all TV and print concepts, headlines and copy
- Successfully met all established goals and objectives; budgets maintained with positive variance
- Successfully created and managed major renaming and branding initiative that more aptly reflected the evolution of the institution from a capable, community hospital to an advanced, tertiary medical center
- Created and facilitated campus signage redesign reflective of new branding/name
- Managed ongoing process of complete website redesign
- Served as part of Senior Executive Team that produced a \$125 million bottom-line improvement; all marketing metrics (utilization, web traffic, consumer surveys, etc.) were positive throughout tenure

WEST PENN ALLEGHENY HEALTH SYSTEM**1999 – 2009*****Vice President, Communications, Pittsburgh, PA***

- Managed all internal and external communications for the System and its six hospitals including: media relations, print, TV, radio, outdoor advertising and employee communications, collateral materials to both lay and professional audiences, web communications and audio-visual support
- Directed and supervised work of a 40-person staff
- Maintained oversight of a \$5 million department budget, which produced positive budgetary variances during each fiscal year of tenure
- Served as primary spokesperson and speech writer for the organization
- Created all system and hospital-based advertising in-house
- Facilitated name change, graphic identity and initial branding efforts for new system

ELEVENCANTERBURY

ALLEGHENY GEN. HOSPITAL/HEALTH EDUCATION & RESEARCH 1988 – 1999

Vice President, Communications, Pittsburgh, PA (1990 – 1999)

- Directed all communications functions for what was at the time, the state of Pennsylvania's largest not-for-profit healthcare system
- Managed state-wide department consisting of over 150 employees and with an annual operating budget of \$24 million
- Coordinated all departmental functions and responsibilities for both Pittsburgh and Philadelphia Offices
- Served as organization's spokesperson during the bankruptcy of AHERF and maintained positive media relations during crisis with both Pittsburgh and Philadelphia outlets

Assistant Vice President, Communications (1988 – 1990)

- Recruited to position by senior management of the organization

KETCHUM PUBLIC RELATIONS 1987 – 1988

Senior Account Executive, Pittsburgh, PA

- Recruited by firm to lead healthcare client services
- Won Ketchum's "Right Way" Award for managing media relations related to Prince Charles' visit to Pittsburgh and participation in the Remaking Cities Conference

PRESBYTERIAN UNIVERSITY HOSPITAL 1984 – 1987

Director, Media Relations, Pittsburgh, PA

- Facilitated proactive and reactive media relations regarding hospital programs and clinical capabilities
- Primary spokesperson for the institution during its meteoric growth as an organ transplant center

EDUCATION

Bachelor of Arts, Communications and Rhetoric, University of Pittsburgh

MEMBERSHIPS

Board Member (Vice President), Epilepsy Foundation of West Pennsylvania

Board Member, Leadership Pittsburgh, Inc.

Board Member, National Kidney Foundation

Board Member, Juvenile Diabetes Research Foundation

Board Member, Roberto Clemente Foundation

Executive Committee Member, Westmoreland County Chamber of Commerce

Guest Lecturer: Carnegie Mellon University, Duquesne University, University of Pittsburgh

AWARDS AND HONORS

- 100+ individual and departmental awards for excellence in marketing and communications, including two American Hospital Association Touchstones
- 1994 Public Relations Society of America (Pittsburgh Chapter) "Renaissance Communicator of the Year"
- 1996 Bizmark "Advertising Executive of the Year"; 1999 Bizmark "Relations Executive of the Year"
- 2010 Mark of Excellence Award (Florida Hospital Association) for branding campaign.
- 2010 Gold Telly Award (Hospital TV Spots)
- 2012 Silver Addy (Hospital TV Spots)
- 2014 Comcast LAMP Award (National Competition for Best Regional Advertiser)
- 2017 Gold Cancer Awareness Advertising Award (Cyberknife)

Exhibit B*List of Materials Considered*

Academic & Industry Literature		
Document	Abbreviation	Bates Range
Cutler <i>et al.</i> , <i>The Role of Information in Medical Markets: An Analysis of Publicly Reported Outcomes in Cardiac Surgery</i> , AM. ECONOMIC REV., 94(2):342–346 (2004)	Cutler	PBHN000002338– PBHN000002342
Ellis <i>et al.</i> , <i>National Evaluation of Patient Preferences in Selecting Hospitals and Healthcare Providers</i> , PATIENT-CENTERED CARE, 58:867–873 (2020)	Ellis	PBHN000002343– PBHN000002349
Godwin <i>et al.</i> , <i>One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2022</i> , KFF (October 1, 2024) and supporting data, available at https://www.kff.org/health-costs/issue-brief/one-or-two-health-systems-controlled-the-entire-market-for-inpatient-hospital-care-in-nearly-half-of-metropolitan-areas-in-2022/	Godwin	PBHN000002512– PBHN000002520
Guardado, <i>Competition in Hospital Markets, 2013-2021</i> , AMA POLICY RESEARCH PERSPECTIVES (March 2024), available at https://www.ama-assn.org/system/files/prp-competition-in-hospital-markets.pdf	Guardado	PBHN000002271– PBHN000002290
Hibbard <i>et al.</i> , <i>Hospital Performance Reports: Impact on Quality, Market Share, and Reputation</i> , HEALTH AFFAIRS, 24(4):1150–1160 (2005)	Hibbard	PBHN000003099– PBHN000003110
Huppertz <i>et al.</i> , <i>Hospital Advertising, Competition, and HCAHPS: Does It Pay to Advertise?</i> , HEALTH SERVS. RES., 52(4):1590-1611 (2016)	Huppertz	PBHN000002490– PBHN000002511
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Document	Abbreviation	Bates Range
May 13, 2025 Declaration of Erik Cazares and exhibits thereto	Cazares Declaration	PBHN000002155– PBHN000002181
May 13, 2025 Declaration of Jerad Hanlon and exhibits thereto	Hanlon Declaration	PBHN000002182– PBHN000002193
May 14, 2025 Declaration of Heather Havericak and exhibits thereto	Havericak Declaration	PBHN000002104– PBHN000002127

May 13, 2025 Declaration of Cynthia McCauley and exhibits thereto	McCauley Declaration	PBHN000002207– PBHN000002234
May 14, 2025 Declaration of Sheri Montgomery and exhibits thereto	Montgomery Declaration	PBHN000002128– PBHN000002154

Litigation Documents	
Document	Abbreviation
Complaint and Demand for Jury Trial, <i>Good Samaritan Medical Center, Inc., Delray Medical Center, Inc., Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center, St. Mary's Medical Center, Inc., and West Boca Medical Center, Inc. v. The Leapfrog Group</i> , Case No. 9:25-cv-80526, Dkt. 1 (April 30, 2025)	Complaint
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Good Samaritan Medical Center, Inc.'s Response to First Set of Interrogatories (July 25, 2025)	
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LEAPFROG00132898–LEAPFROG00132899
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EXHIBIT B

**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION**

GOOD SAMARITAN MEDICAL CENTER
INC., DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. D/B/A PALM BEACH
GARDENS MEDICAL CENTER, ST.
MARY'S MEDICAL CENTER, INC., AND
WEST BOCA MEDICAL CENTER, INC.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

Case No. 9:25-CV-80526

Expert Report of Jonah Berger, Ph.D.

August 7, 2025

Table of Contents

I.	Qualifications.....	1
II.	Case Background and Allegations	2
III.	Assignment	5
IV.	Summary of Opinions	6
V.	“D” or “F” TLG Hospital Safety Grades Likely Negatively Impact Consumers’ Perceptions of Plaintiff Hospitals’ Quality	8
	A. Third-Party Ratings Have Been Found to Affect Consumers’ Hospital Quality Perceptions.....	8
	B. TLG’s Hospital Safety Grades Present Hospital Performance Using Evaluative Categories and Labels, Which Can Increase the Influence of Hospital Safety Grades on Consumers’ Perceptions of Hospital Quality.....	10
VI.	“D” or “F” TLG Hospital Safety Grades Likely Deter Consumers from Choosing Plaintiff Hospitals	13
	A. Third-Party Ratings, Like TLG’s Hospital Safety Grades, Have Been Found to Affect Consumer Decision-Making.....	14
	B. Hospital Choice is a Complex Decision Which Increases Reliance on Heuristic Cues like TLG’s Hospital Safety Grades.....	16
	C. “D” or “F” TLG Hospital Safety Grades Likely Evoke Negative Emotions about Plaintiff Hospitals, Which Can Lead Consumers to Be Less Likely to Seek Out Other, Potentially Positive Information about Plaintiff Hospitals	21
	D. TLG Presents the Four Imputed Measures as Fundamental Aspects of Medical Care and Frames its Hospital Safety Grades as Essential Inputs into Consumers’ Hospital Choices.....	27
VII.	Future, Repeated Publications of “D” or “F” Hospital Safety Grades Would Be Expected to Have a Long-Term, Negative Impact on Perceptions of and Choice for Plaintiff Hospitals	29
VIII.	Many Consumers Would Be Unlikely to Understand that TLG Assigns the Minimum Score on the Imputed Measures and the Impact of this Practice on the Safety Grades TLG Assigns to Non-Participating Hospitals, Based on TLG’s Imputation Disclosures	31
	A. TLG Does Not Directly Disclose Information on its Practice of Assigning the Minimum Score to Non-Participating Hospitals on TLG’s Hospital Safety Grade Pages33	
	B. TLG Does Not Directly Disclose that its Minimum Score Assignment Lowers Non-Participating Hospitals’ Hospital Safety Grades	48

C. It Is Unlikely that Many Consumers Read TLG’s Footnote Disclosure Located at the Bottom of the Hospital Safety Grade Page 50

D. It Is Unlikely that Many Consumers Read TLG’s Disclosure in the Methodology Document..... 52

E. TLG’s Imputation Disclosures May Negatively Impact Consumers’ Perceptions of Plaintiff Hospitals 59

I. Qualifications

1. My name is Jonah Berger. I am a Marketing professor at the Wharton School at the University of Pennsylvania. I received my Ph.D. in Marketing from the Graduate School of Business at Stanford University and my B.A. in Human Judgment and Decision Making, also from Stanford University.

2. My research focuses on consumer behavior, digital marketing, social influence, and technology. I have spent over 20 years studying how consumers make purchase decisions and how firms communicate with and influence consumers. I have published over 75 peer-reviewed articles in top-tier academic journals in marketing, consumer psychology, and other disciplines, including in the *Journal of Marketing Research*, *Journal of Consumer Research*, *Journal of Marketing*, *Marketing Science*, *Journal of Advertising*, and *Journal of Consumer Psychology*. I have also written four best-selling books that have been printed in dozens of different languages. In addition, I have served as an Associate Editor at the *Journal of Marketing* and *Journal of Marketing Research*.

3. I have received numerous awards for my research and writing. In 2014, I received the American Marketing Association's Leonard L. Berry Marketing Book Award, which is given for a book that has had a significant impact in marketing and related sub-fields. In 2015, I was a finalist for the best article published in 2012 in the *Journal of Consumer Research*. In 2017, I received the *Journal of Marketing*'s William F. O'Dell Award for the article that made the most significant, long-term contribution to marketing theory, methodology, and/or practice. I was recognized by the American Marketing Association as a top ten most productive researcher in marketing every year from 2013 to 2024 (the most recent year of the award). In 2023, I received the Sage 10-Year Impact Award, which recognizes articles published in Sage journals with lasting influence in the decade since their publication. In 2024, I was a finalist for the Shelby D. Hunt/Harold H. Maynard Award, which recognizes scholars for significant contributions to marketing theory and thought. In 2025, I received the Sheth Foundation Award for the article published in the *Journal of Marketing* that has made long-term contributions to the field of

marketing. The American Management Association named me one of the top 30 leaders in business and *Fast Company* magazine named me one of the most creative people in business.

4. In addition to my research, I have extensive experience teaching and consulting on these topics. I have won numerous teaching awards from the Wharton School, where I have taught the core graduate marketing curriculum, and have consulted with hundreds of firms (including hospitals) on topics such as consumer behavior, digital marketing, go-to-market strategy, branding, word of mouth, and helping products and ideas catch on. As part of my consulting work, I have helped design and develop grading systems.

5. A complete list of my publications and other academic and professional experience is in my curriculum vitae, which is attached to this report as **Appendix A**. A list of my testimony in the last four years is attached as **Appendix B**.

II. Case Background and Allegations

6. Defendant, The Leapfrog Group (“TLG”), is a not-for-profit organization that evaluates hospital performance by collecting self-reported data in a voluntary survey that TLG administers to hospitals.¹ TLG combines its survey data and other data sources to assign its “Hospital Safety Grades” to hospitals biannually, which purport to represent in a single letter grade how well a hospital keeps patients safe from preventable harm and medical errors.² I understand that TLG communicates the Hospital Safety Grades it assigns to hospitals to the general public through press releases, media communications, and its consumer-facing website, www.hospitalsafetygrade.org, and also markets and references the grades on its other website, www.leapfroggroup.org, among other avenues.³

¹ See, e.g., “About Leapfrog Group”, *The Leapfrog Group*, <https://www.leapfroggroup.org/about>, PBHN000003152–4.

² See, e.g., Motion to Dismiss, Exhibit 4, p. 2 (citing “About the Grade”, *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/about-the-grade>), PBHN000002619–25.

³ Complaint and Demand for Jury Trial, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526, April 30, 2025 (“Complaint”), ¶ 1. See also “Leapfrog’s Spring 2025 Safety Grades Are In — New Trend Data Shows One in Eight Hospitals Sustained an ‘A’ for More Than Two Years,” *The Leapfrog Group*, May 1, 2025, <https://www.leapfroggroup.org/news-events/leapfrog%E2%80%99s-spring-2025-safety-grades-are-%E2%80%94-new-trend-data-shows-one-eight-hospitals>, PBHN000002523–4; “Press Resources: Spring 2025 Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/for-press>, PBHN000004113–5.

7. For each hospital it rates, TLG reports both an overall letter grade and numeric scores on individual “measures” (e.g., “Patient falls and injuries”) underlying the letter grade.⁴ Scores for some measures rely solely on hospitals’ self-reported data from TLG’s survey. When a hospital chooses not to participate in TLG’s survey, TLG uses an “imputation model” to assign scores to the hospital for four such measures (i.e., “Handwashing,” “Doctors order medications through a computer,” “Safe medication administration,” and “Specifically trained doctors care for ICU patients”).⁵ Throughout this report, I will refer to these four measures collectively as the “imputed measures.”

8. Five hospitals in Florida—Good Samaritan Medical Center, Inc., Delray Medical Center, Inc., Palm Beach Gardens Medical Center, St. Mary’s Medical Center, Inc., and West Boca Medical Center, Inc. (collectively “Plaintiffs” or “Plaintiff Hospitals”)—allege that, in Fall 2024, TLG changed its scoring methodology such that “any hospital declining to provide data [by declining to participate in TLG’s survey] would automatically fail” on the imputed measures.⁶

9. Specifically, prior to Fall 2024, Plaintiffs allege that TLG’s “imputation model” assigned non-participating hospitals “a score based on the average score applicable to similarly situated hospitals.”⁷ In Fall 2024, however, Plaintiffs allege that TLG modified its “imputation model” to instead “assign[] the lowest possible score to non-participating hospitals” (which I understand TLG refers to as a score reflecting “Limited Achievement”).⁸ I will refer to the practice of

⁴ See, e.g., Motion to Dismiss, Exhibit 28 (citing “Good Samaritan Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center>), PBHN000002641–3.

⁵ The listed names are the names of the measures that appear on TLG’s Hospital Safety Grade Pages. Plaintiffs refer to these four measures as “Computerized Order Entry (‘CPOE’), Bar Code Medication Administration (‘BCMA’), ICU Physician Staffing (‘IPS’), and Hand Hygiene Score” in their Complaint. As background, TLG relies on self-reported data for 12 of 22 measures to determine an overall letter grade. When a hospital does not participate in TLG’s survey, three measures are dropped, five measures use government data as a substitute, and the four remaining measures are assigned values through TLG’s imputation model. Complaint, ¶¶ 48–51. See also “Scoring Methodology: Fall 2024 Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024.pdf> (“Fall 2024 ‘Scoring Methodology’”), pp. 5–8, PBHN000003044–69; “Scoring Methodology: Spring 2025 Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025.pdf> (“Methodology Document”), pp. 4–8, PBHN000003012–40. I understand identical copies of the Methodology Document exist at <https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025-1.pdf> and <https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025-2.pdf>.

⁶ Complaint, ¶¶ 3, 9–13.

⁷ Complaint, ¶ 50.

⁸ Complaint, ¶ 50 (“Beginning in Fall 2024, however, TLG modified its imputation model. It now assigns the lowest possible score to non-participating hospitals.”), ¶ 52 (“For the four imputed measures (CPOE, BCMA, IPS, and Hand Hygiene), if a hospital does not participate in TLG’s survey, TLG assigns ‘a point value that is equivalent to receiving ‘Limited Achievement’ for this measure’—its lowest possible score—without any factual basis. The result is that hospitals who elect not to participate in TLG’s survey receive only 60 out of 400 possible points in these four categories—resulting in artificially deflated overall grades with no basis in fact and no correlation to a hospital’s actual safety performance.”).

assigning the minimum score on the imputed measures as TLG's "imputation methodology." I understand that TLG purports to disclose the imputation methodology in notes and documentation on [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org) and [leapfroggroup.org](https://www.leapfroggroup.org) (together "TLG's websites"), which I will refer to as TLG's "imputation disclosures."⁹

10. According to the Plaintiffs, as a result of the change, Plaintiff Hospitals received "Ds and Fs ... for the first time."¹⁰ Specifically, TLG assigned the following grades for Plaintiff Hospitals in Fall 2024 and Spring 2025, respectively, and marketed and disseminated this information, including via its websites:¹¹

- Good Samaritan Medical Center: F, D
- Delray Medical Center: F, F
- Palm Beach Gardens Medical Center: F, F
- St. Mary's Medical Center: D, D
- West Boca Medical Center: D, F

11. Plaintiffs allege that TLG "deceives consumers by inventing negative data" about non-participating hospitals and fails to adequately disclose that its "D" or "F" Hospital Safety Grades for Plaintiff Hospitals are the result of the hospitals' decisions to not to respond to TLG's survey, not their actual performance on safety.¹² Plaintiffs further allege that TLG's Hospital Safety Grades have caused "severe, ongoing, and irreparable harm to Plaintiffs," including "harm to their reputation," and have "caused Plaintiffs' patients to move their procedures from Plaintiffs to Plaintiffs' competitors."¹³

⁹ Defendant the Leapfrog Group's Motion to Dismiss Pursuant to Federal Rule of Civil Procedure 12(b)(2) And 12(b)(6) and Incorporated Memorandum of Law in Support of the Same, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526-DMM, June 27, 2025 ("Motion to Dismiss"), pp. 8–9.

¹⁰ Complaint, ¶¶ 2–3.

¹¹ "Good Samaritan Medical Center", *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center>; "Delray Medical Center", *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/delray-medical-center>; "Palm Beach Gardens Medical Center", *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>; "St. Mary's Medical Center", *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/st-marys-medical-center-west-palm-beach-fl>; "West Boca Medical Center", *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/west-boca-medical-center>; The Plaintiff Hospitals' Response in Opposition to the Leapfrog Group's Motion to Dismiss Pursuant to Federal Rules of Civil Procedure 12(b)(2) And 12(b)(6), *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526-DMM, July 11, 2025 ("Opposition to the Motion to Dismiss"), Exhibit D, p. 1 (citing "Follow-Up Statement from Leapfrog President and CEO Leah Binder on Tenet Healthcare Hospitals' Lawsuit to Suppress Poor Safety Grade Performance," *The Leapfrog Group*, May 2, 2025, <https://www.leapfroggroup.org/news-events/follow-statement-leapfrog-president-and-ceo-leah-binder-tenet-healthcare-hospitals%E2%80%99>), PBHN000002638–40.

¹² Complaint, ¶¶ 52, 54.

¹³ Complaint, ¶¶ 103, 116.

III. Assignment

12. I have been asked by counsel for Plaintiffs to assess whether, and in what ways, low or failing TLG Hospital Safety Grades may impact consumers' perceptions of Plaintiff Hospitals and consumers' decisions to seek care at Plaintiff Hospitals. I have also been asked to assess whether and how repeated publication of low or failing TLG Hospital Safety Grades (i.e., future grades using the same imputation methodology) could affect consumers' perceptions of, and decisions to seek care at, Plaintiff Hospitals. Finally, I have been asked by counsel to assess the extent to which TLG's imputation disclosures would be expected to affect consumers' understanding of TLG's imputation methodology (i.e., TLG's practice of assigning the minimum score on the imputed measures and not basing it on hospital performance) and consumers' understanding of the impact of TLG's imputation methodology on TLG's Hospital Safety Grades for non-participating hospitals, including Plaintiff Hospitals.

13. A list of materials I have considered to date in connection with this assignment is attached as **Appendix C**. I reserve the right to supplement or amend my opinions should new information become available.¹⁴

14. I am being compensated at my standard billing rate of \$1,200 per hour. I have been assisted in this matter by staff of Cornerstone Research, who worked at my direction. I receive compensation from Cornerstone Research based on its collected staff billings for its support of me in this matter. Neither my compensation in this matter nor my compensation from Cornerstone Research is in any way contingent or based on the content of my opinion or the outcome of this or any other matter.

¹⁴ I understand that TLG has the opportunity to present opinions from one or more experts in this matter and that the parties are continuing to produce documents and evidence in this case. For example, I have been informed that TLG produced more than 250,000 documents in the four days before this report was due, including 93,000 documents on Sunday, August 3 and 156,000 documents on Wednesday, August 6. As I have not yet had the opportunity to meaningfully review these documents, I reserve the right to adjust my opinions based on my review of documents recently produced or that will be produced in this litigation. I also reserve the right to supplement my analysis and conclusions set forth in this report to respond to the opinions of TLG's expert(s) or based upon any additional discovery performed or disclosed by the parties.

IV. Summary of Opinions

15. TLG's "D" or "F" Hospital Safety Grades for Plaintiff Hospitals likely impact consumers' perceptions of Plaintiff Hospitals and deter consumers from choosing to receive care there. Moreover, if TLG continues to publish low or failing grades for Plaintiff Hospitals in the future, these effects are likely to be amplified. While TLG purports to disclose its imputation methodology to consumers, consumers are unlikely to understand that TLG assigns the minimum possible score on the imputed measures and the impact of the imputation methodology on the Hospital Safety Grades for non-participating hospitals.

16. TLG's "D" or "F" Hospital Safety Grades for Plaintiff Hospitals likely negatively impact consumers' perceptions of Plaintiff Hospitals' quality. Research has found that third-party ratings, like TLG's Hospital Safety Grades, can affect consumers' perceptions of a product or service's quality. Further, third-party ratings are likely to be particularly impactful for healthcare services and hospital choice because consumers are unlikely to effectively evaluate a hospital's quality by themselves. Moreover, the information TLG presents on its Hospital Safety Grade Pages, including its "A" through "F" letter grades and summaries of performance using a red, yellow, green color scale, are examples of evaluative categories and labels, which are a form of information presentation that indicates how information should be evaluated. Presenting evaluative categories and labels alongside information has been shown to increase the influence of that information on consumers' perceptions in many contexts, including in the specific context of information on hospital quality.

17. Beyond perceptions, TLG's "D" or "F" Hospital Safety Grades for Plaintiff Hospitals also likely affect consumers' *choices* and deter consumers from choosing Plaintiff Hospitals. Research has found that third-party ratings, like TLG's Hospital Safety Grades, impact consumers' decision-making across a variety of healthcare contexts. Indeed, TLG itself publicized a study on the effect that letter grades for hospital safety, modeled after TLG's Hospital Safety Grades, had on consumers' choices. The study found that respondents almost always chose a hospital rated as safer when presented with such information, even if it was more expensive. Such an effect would be consistent with research on consumer decision-making. Hospital choice is a complex decision, and consumers are more likely to rely on decision-making shortcuts, or heuristics, like TLG's

Hospital Safety Grades to make decisions. Moreover, “D” or “F” TLG Hospital Safety Grades are likely to evoke negative emotions from consumers about Plaintiff Hospitals. In such emotional states, consumers are less likely to seek out and more likely to disregard other information about Plaintiff Hospitals, including positive or contradictory information about the graded hospital. Finally, statements on TLG’s own website are consistent with the premise that Hospital Safety Grades can influence consumers’ hospital choices, and TLG presents the four imputed measures as fundamental aspects of medical care and frames its Hospital Safety Grades as essential inputs into consumers’ hospital choices.

18. The effects of TLG’s “D” or “F” Hospital Safety Grades for Plaintiff Hospitals would be intensified if TLG continues to repeatedly publish “D” or “F” Hospital Safety Grades in the future. Such a practice would be expected to have a long-term, negative impact on perceptions of, and choice for, Plaintiff Hospitals. In particular, consumers may be repeatedly exposed to low or failing grades for Plaintiff Hospitals through future publications, and research has found that consumers who are repeatedly exposed to information are more likely to be persuaded by that information.

19. TLG’s imputation disclosures are unlikely to help consumers understand that TLG assigns the minimum score on the imputed measures and the impact this has on the safety grades TLG assigns to non-participating hospitals. In fact, TLG does not directly disclose the relevant information on its Hospital Safety Grade Pages. Instead, TLG includes a disclosure in the footnote of its Hospital Safety Grade Pages for the imputed measures (“footnote disclosure”) that fails to explain that the minimum score is assigned for the imputed measure, or that such assignment lowers the hospital’s overall Hospital Safety Grade. The only disclosure that explains the imputation methodology is found on page 16 of TLG’s 28-page Spring 2025 “Scoring Methodology” document (“methodology document”), which requires multiple steps to access from a TLG’s Hospital Safety Grade Page. In fact, it is unlikely that many consumers would read either disclosure, because TLG’s footnote disclosure is located at the bottom of the Hospital Safety Grade Pages and because it takes multiple steps to access TLG’s methodology document. Finally, TLG’s imputation disclosures themselves use language that may lead consumers to place the responsibility for missing data on Plaintiff Hospitals and, thus, negatively impact consumers’ perceptions of Plaintiff Hospitals.

V. “D” or “F” TLG Hospital Safety Grades Likely Negatively Impact Consumers’ Perceptions of Plaintiff Hospitals’ Quality

A. Third-Party Ratings Have Been Found to Affect Consumers’ Hospital Quality Perceptions

20. Third-party ratings can influence consumers’ perceptions, especially in the context of healthcare. The academic literature has repeatedly shown that third-party ratings, such as TLG’s Hospital Safety Grades, can affect consumers’ perceptions of the quality of a product or service. These third-party ratings are likely to be particularly impactful for healthcare services and hospital choice because many consumers lack the requisite knowledge and expertise to effectively evaluate a hospital’s quality by themselves. As a result, third-party ratings, such as TLG’s Hospital Safety Grades, fill that vacuum and can significantly impact consumers’ perceptions of the quality of hospitals, including Plaintiff Hospitals.

21. The academic literature has found that, in a variety of contexts, consumer perceptions of a product or service’s quality can be influenced by third-party ratings. A 2022 study of consumers’ responses to product ratings, for example, found that consumers tended to perceive products with positive ratings as higher quality than products that had negative or ambiguous ratings.¹⁵ Similarly, a 2018 study, which presented participants with the description of a product and different reviews of the product, found that strongly negative reviews adversely affected participants’ attitudes toward the product manufacturer and lowered their product satisfaction.¹⁶

22. The effect of third-party ratings on perceived quality is likely to be particularly impactful on consumer perceptions of hospital quality because consumers often lack the knowledge and expertise necessary to evaluate hospital quality themselves. Healthcare, including hospital care, is a prototypical example of a “credence good,” which is a good or service whose quality can be difficult for consumers to reliably assess.¹⁷ Healthcare in general is such a good because consumers “can hardly determine the extent of the service that was required ... whether necessary treatments

¹⁵ Pascucci, F., et al. (2022), “Exploring the Relationships Between Perception of Product Quality, Product Ratings, and Consumers’ Personality Traits: An Eye-Tracking Study,” *Journal of Neuroscience, Psychology, and Economics*, 15, 2, 89–100 at p. 94, PBHN000004088–100.

¹⁶ Esmark Jones, C. L., et al. (2018), “Tell It Like It Is: The Effects of Differing Responses to Negative Online Reviews,” *Psychology and Marketing*, 35, 2, 891–901 at pp. 898–899, PBHN000003576–87.

¹⁷ Dulleck, U., et al. (2011), “The Economics of Credence Goods: An Experiment on the Role of Liability, Verifiability, Reputation, and Competition,” *American Economic Review*, 101, 2, 526–555 at p. 526, PBHN000003524–54.

were not performed ... [and] the quality of the services he has purchased.”¹⁸ Moreover, hospital care, specifically, is a credence good because many consumers lack the medical expertise necessary to identify and evaluate information about the quality of care a hospital offers.¹⁹ This is true even *after* consumers receive treatment, because health outcomes are not always indicative of quality of care.²⁰ Even assuming consumers *were* able to assess hospital quality based on experience alone, many consumers only consider or experience hospital care infrequently and are thus unlikely to have sufficient direct or recent experience, if any at all, to form a perception of hospital quality.²¹

23. Because many consumers are unable to assess hospital quality directly, they are more likely to rely on outside information sources, like TLG’s Hospital Safety Grades, to form their perceptions. Indeed, research has found that online reviews, rankings, and ratings can affect perceptions of credence goods, including healthcare services. For example, one study assessing physician reviews found that online reviews significantly influenced respondents’ perceptions of the physician’s technical skills.²² A 2019 study conducted by the consulting firm McKinsey found that when respondents were asked what information would give them the most confidence that they would receive high quality care, nearly 40% of respondents selected “a facility has a good

¹⁸ Emons, W. (1997), “Credence Good and Fraudulent Experts,” *RAND Journal of Economics*, 28, 1, 107–119 at p. 107, PBHN000003562–75; Kerschbamer, R., et al. (2023), “Credence Goods Markets, Online Information, and Repair Prices: A Natural Field Experiment,” *Journal Of Public Economics*, 104891, 1–14 at pp. 1–2, PBHN000003893–906; Lantzy, S., et al. (2021), “Online Reviews of Credence Service Providers,” *Journal of Public Policy and Marketing*, 40, 1, 27–44 at pp. 27–28, PBHN000003933–51.

¹⁹ Kahn, B. E., et al. (1997), “Examining Medical Decision Making from a Marketing Perspective,” *Marketing Letters*, 8, 3, 361–375 (“Kahn et al. (1997)”) at p. 362, PBHN000003833–48.

²⁰ Kahn et al. (1997), p. 362, PBHN000003833–48 (“...there is a stochastic relationship between health outcomes and the quality of care. For example, one cannot automatically assume a patient who died after being hospitalized for cancer was improperly treated. Because health outcomes are not always diagnostic about the quality of treatment, consumers may not know that they have received improper treatment even when they experience adverse health outcomes.”); Lantzy, S., et al. (2021), “Online Reviews of Credence Service Providers,” *Journal of Public Policy and Marketing*, 40, 1, 27–44 at pp. 27–28, PBHN000003933–51 (“For example, a patient may begin to feel better after treatment, but if she does not have medical training, she may never know whether her doctor correctly diagnosed her symptoms or whether she would have felt equally good without treatment. Or, a patient may not feel better after treatment and blame the doctor, even though he received state-of-the-art care.”).

²¹ Arrow, K. J. (1963), “Uncertainty and the Welfare Economics of Medical Care,” *American Economic Review*, 53, 5, 941–973 at p. 951, PBHN000003182–215. Less than 8% of people in the United States spend a night in a hospital each year. See, “Summary Health Statistic: National Health Interview Survey,” Table P-10a, *Centers for Disease Control and Prevention, National Center for Health Statistics*, 2018, PBHN000004188–96. The CDC also reported that in 2018, only 5.2% of the U.S. population aged 1–64 experienced a hospital stay in the last year and only 21.3% had visited an emergency department in the past year. See, “Hospitalization,” *Centers for Disease Control and Prevention, National Center for Health Statistics*, <https://www.cdc.gov/nchs/hus/topics/hospitalization.htm>, PBHN000003751–60.

²² Li, S., et al. (2019), “Effects of Online Physician Reviews and physician Gender on Perceptions of Physician Skills and Primary Care Physician (PCP) Selection,” *Health Communication*, 34, 11, 1250–1258 at pp. 1250, 1256, PBHN000003952–61.

reputation for quality / scored well by publications.”²³ Similarly, in another 2019 survey of U.S. consumers, more than one third of respondents (34%) reported using hospital ranking websites to develop their impressions of a hospital’s reputation.²⁴ Further, a 2020 study found that negative comments left on physician-rating websites, even if exaggerated or untrue, can cause reputational harm for physicians because of “the limited ability of the readers ... to evaluate whether the accusation in the negative review corresponds to the truth or not.”²⁵ Overall, these findings suggest that TLG’s Hospital Safety Grades are likely to influence perceived hospital quality and low or failing Hospital Safety Grades likely negatively impact consumers’ perceptions of hospital quality.

B. TLG’s Hospital Safety Grades Present Hospital Performance Using Evaluative Categories and Labels, Which Can Increase the Influence of Hospital Safety Grades on Consumers’ Perceptions of Hospital Quality

24. TLG’s Hospital Safety Grades are also likely to have a strong influence on consumers’ perceptions of hospital safety because of how the grades are presented. Specifically, on each Hospital Safety Grade Page, TLG presents an overall letter grade for the hospital, on a scale of “A” to “F,” and, for each measure underlying the letter grade, a dial graphic with a red, yellow, green color scale indicating the hospital’s performance on that measure, as shown in the excerpt in Exhibit 1. Both the letter grade and the color-scaled dial graphic exemplify what research describes as “evaluative” categories or labels. Evaluative categories or labels refer to forms of information presentation that indicate how information should be evaluated or judged.²⁶ Numeric information (e.g., 5%), for example, can be presented alongside an evaluative label, such as “high”

²³ “Consumer Decision Making in Healthcare: The Role of Information Transparency,” *McKinsey & Company*, July 2020, Exhibit 3, <https://www.mckinsey.com/~/media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/Consumer%20decision%20making%20in%20healthcare/Consumer-decision-making-in-healthcare-The-role-of-information-transparency.pdf>, PBHN000003405–16.

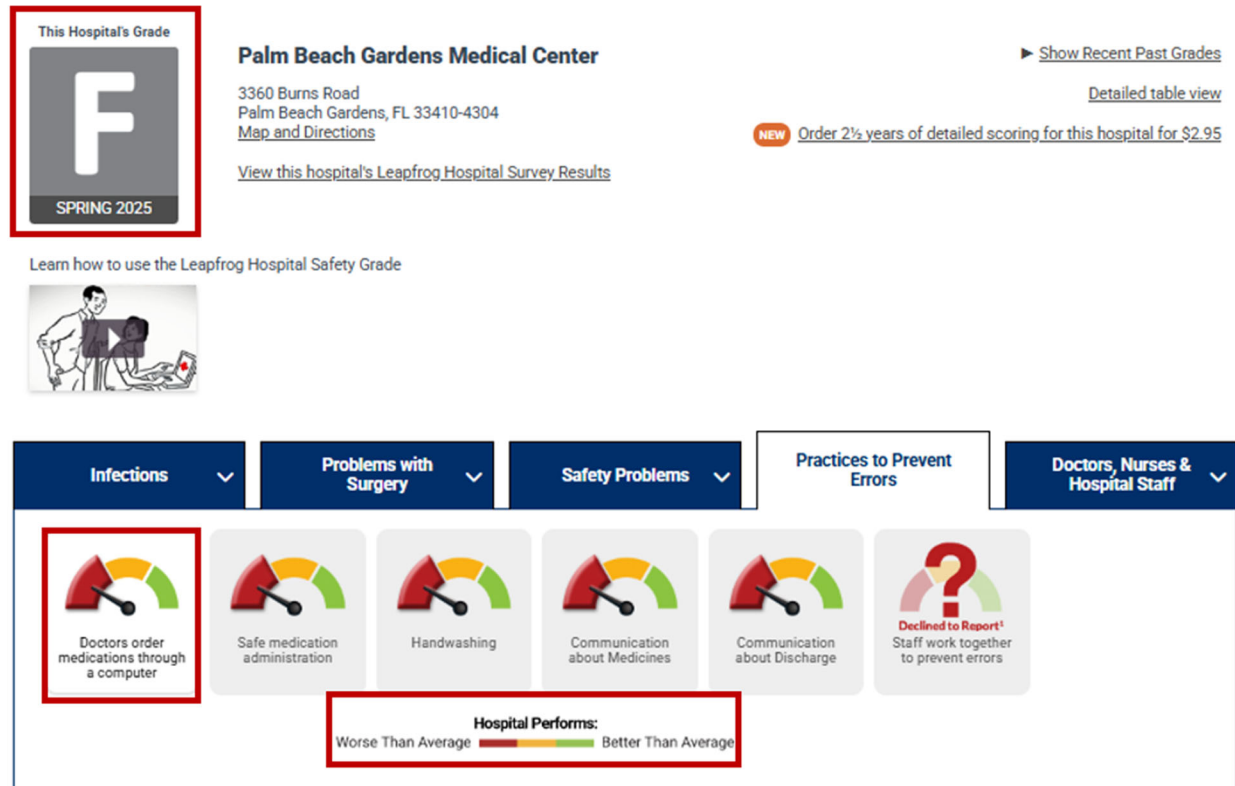
²⁴ Ziemba, J. B., et al. (2019), “Consumers’ Association of Hospital Reputation with Healthcare Quality,” *Journal for Healthcare Quality*, 41, 4, 251–258 at p. 257, PBHN000004354–61.

²⁵ Arendt, F., et al. (2020), “Dealing with Negative Reviews on Physician-Rating Websites: An Experimental Test of How Physicians Can Prevent Reputational Damage Via Effective Response Strategies,” *Social Science & Medicine*, 266, 113442, 1–9 at pp. 2, 6, PBHN000003158–66.

²⁶ Dieckmann, N. F., et al. (2012), “Making Sense of Uncertainty: Advantages and Disadvantages of Providing an Evaluative Structure,” *Journal of Risk Research*, 15, 7, 717–735 at p. 718, PBHN000003497–516; Peters, E., et al. (2009), “Bringing Meaning to Numbers: The Impact of Evaluative Categories on Decisions,” *Journal of Experimental Psychology: Applied*, 15, 3, 213–227 (“Peters et al. (2009)”) at p. 214–215; Cadario, R. and P. Chandon (2020), “Which Healthy Eating Nudges Work Best? A Meta-Analysis of Field Experiments,” *Marketing Science*, 39, 3, 465–486 at p. 468, PBHN000003368–90.

or “low” or “good” or “bad,” which helps consumers interpret the numeric information.²⁷ Similarly, letter grades (e.g., “A” to “F”) and color schemes (e.g., red, yellow, green scale) provide information on how information should be interpreted (i.e., positive, average, or negative performance).²⁸

Exhibit 1 Presentation of Information on TLG’s Hospital Safety Grade Page



Source: “Palm Beach Gardens Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays an excerpt of the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the “Practices to Prevent Errors” tab and “Doctors order medications through a computer” measure. Parts of the page marked by the red boxes show the overall letter grade, the measure currently being viewed and its associated color-scaled dial graphic, and the legend that defines the colors of the dial graphics.

²⁷ Dieckmann, N. F., et al. (2012), “Making Sense of Uncertainty: Advantages and Disadvantages of Providing an Evaluative Structure,” *Journal of Risk Research*, 15, 7, 717–735 at p. 718, PBHN000003497–516.

²⁸ Cadario, R. and P. Chandon (2020), “Which Healthy Eating Nudges Work Best? A Meta-Analysis of Field Experiments,” *Marketing Science*, 39, 3, 465–486 at p. 468, PBHN000003368–90; Moller, A. C., et al. (2009), “Basic Hue-Meaning Associations,” *Emotion* 9, 6, 898–902 at p. 901; Lipnevich, A. A. and J. K. Smith (2009), “Effects of Differential Feedback on Students’ Examination Performance,” *Journal of Experimental Psychology: Applied*, 15, 4, 319–333 at p. 330.

25. Academic research finds that evaluative categories and labels not only help consumers make sense of information, but they also increase the influence such information has on consumers' perceptions. For example, in a 2009 study, researchers provided participants with three indicators of hospital quality: (1) percentage of pneumonia patients who survived while being treated; (2) percentage of heart attack patients given recommended treatment; and (3) percentage of patients who rated their care as very good or excellent. The indicators could take numeric values ranging from 80 to 100 for one of the indicators (i.e., percentage of pneumonia patients who survived while being treated) and 0 to 100 for the remaining two.²⁹ The researchers assigned evaluative categories to the numeric values for each indicator. For example, for the 0–100 indicators, the researchers labeled 0–60 “poor,” 60–70 “fair,” 70–80 “good,” and “80–100” excellent. Respondents were then presented with the three indicators in one of two formats: either only numerically (e.g., 93%) or numerically *and* evaluative categories (e.g., 93% and the evaluative category “excellent”).³⁰ The researchers then asked participants to rate the hospital’s “attractiveness”—how attractive the hospital was as an option based on the information provided.³¹ Results indicated that including the evaluative categories (i.e., category labels) led respondents to give the quality indicators greater weight in determining the hospitals’ “attractiveness.”³² In other words, pairing the numerical information with the evaluative category had a greater effect on consumers’ perceptions.

26. Similarly, in a 2021 study, researchers presented participants with consumer products and information about the products’ attributes, and asked them to rate attractiveness of each product.³³ The attribute information provided was either numeric only (e.g., the bike has battery power of 800 Wh) or numeric with evaluative categories (e.g., the bike has battery power of 800 Wh, which is “excellent”).³⁴ An attribute such as battery power should be more attractive when it has a higher numeric value. Results indicated that when participants were provided with evaluative categories in addition to numeric values, they were more likely to rate a product with a higher numeric value

²⁹ Peters et al. (2009), pp. 215–217.

³⁰ Peters et al. (2009), pp. 215–217.

³¹ Peters et al. (2009), pp. 215–217.

³² Peters et al. (2009), pp. 218, 225.

³³ Tiede, K. E., et al. (2022), “Numeracy, Numeric Attention, and Number Use in Judgment and Choice,” *Journal of Behavioral Decision Making*, 35, 3, e2264 (“Tiede et al. (2022)”) at p. 4, PBHN000004255–71.

³⁴ Tiede et al. (2022), p. 5, PBHN000004255–71.

for the attribute as attractive. That is, including evaluative labels alongside the numeric information significantly increased participants' reliance on the numeric information in their product ratings.³⁵

27. TLG's presentation of its Hospital Safety Grade Pages using evaluative categories, including overall letter grades, would therefore influence how consumers would react to the information. Specifically, TLG transforms the data about a hospital into an overall safety score with a prominently displayed letter grade, which is precisely the type of evaluative categorization that would increase consumers' reliance on those grades, especially in the healthcare context where many consumers lack the ability to assess hospital quality on their own. As a result, the "D" or "F" Hospital Safety Grades TLG assigned to Plaintiff Hospitals would be likely to both impact consumers' perceptions of the quality of care at these hospitals negatively and, as I will discuss below in Section VI, deter consumers from seeking care at Plaintiff Hospitals.

VI. "D" or "F" TLG Hospital Safety Grades Likely Deter Consumers from Choosing Plaintiff Hospitals

28. There are many reasons why TLG's Hospital Safety Grades can influence consumers' hospital choices.³⁶ First, studies have shown that third-party ratings, like TLG's Hospital Safety Grades, can impact consumers' hospital choices. Second, hospital choice is a complex decision in which consumers are likely to rely on decision-making shortcuts, such as prioritizing information that is simple to process (e.g., TLG's Hospital Safety Grades presented in the form of letter grades), and relying on emotional responses to information about available options (e.g., negative emotional responses to low or failing TLG Hospital Safety Grades). Third, consumers experiencing a negative emotional reaction to low or failing Hospital Safety Grades would be unlikely to seek out, and more likely to disregard, additional information about that hospital,

³⁵ Tiede et al. (2022), pp. 6–7, PBHN000004255–71.

³⁶ In some cases, consumers' hospital choices may be dictated by external factors, such as insurance coverage, doctor affiliation, or lack of availability of multiple hospitals. This section focuses on consumer decision-making when consumers are able to choose between multiple hospitals. See "Consumer Choice in U.S. Health Care: Using Insights from the Past to Inform the Way Forward," *The Commonwealth Fund*, November 30, 2021, <https://www.commonwealthfund.org/publications/fund-reports/2021/nov/consumer-choice-us-health-care-using-insights-from-past>, PBHN000003391–404; "Consumers in Health Care: The Burden of Choice," *California HealthCare Foundation*, October 2005, <https://www.chcf.org/wp-content/uploads/2017/12/PDF-ConsumersInHealthCareBurdenChoice.pdf>, pp. 8, 26, PBHN000003417–50.

including positive information about the hospital that may contradict TLG's Hospital Safety Grade. Finally, consistent with the premise that Hospital Safety Grades can influence consumers' hospital choices, TLG publicizes its Hospital Safety Grades and expressly instructs consumers to use both the imputed measures and its overall grades as critical inputs in their hospital decision-making processes.

A. Third-Party Ratings, Like TLG's Hospital Safety Grades, Have Been Found to Affect Consumer Decision-Making

29. Research in a variety of contexts has found that ratings from third-party organizations can affect consumers' choices. In the restaurant industry, for example, a 2002 study found that, after the introduction of mandatory hygiene grade rating disclosures using letter grades, consumer demand increased for restaurants that received higher grades. In particular, restaurants that received "A" and "B" grades experienced statistically significant increases in revenue after the introduction of the grades.³⁷ In the education context, a 2004 study found that, after the introduction of a statewide evaluation system for public schools in Florida using letter grades, the sales price of houses zoned for schools that received "A" grades increased 19.5% relative to the houses zones for schools that received "B" grades.³⁸

30. Similarly, studies have shown that third-party ratings impact consumers' choices in various healthcare contexts. For example:

- A 2022 study examining the effect of Yelp star ratings on hospital admissions in Florida found that "among admissions for elective, inpatient procedures, patients are willing to travel between 5 and 30 percent further to receive care from a hospital with a higher Yelp rating, relative to other hospitals in the market."³⁹

³⁷ In a 2014 interview, TLG CEO Leah Binder stated that the choice to present TLG's Hospital Safety Grades as letter grades was based, in part, on letter grades given to restaurants. See Jin, G. and P. Leslie (2002), "The Effect of Information on Product Quality: Evidence from Restaurant Hygiene Grade Cards," *Quarterly Journal of Economics*, 118, 2, 409–451 at p. 429, PBHN000003789–832; Wong, M., et al. (2015), "Impact of Letter-Grade Program on Restaurant Sanitary Conditions and Diner Behavior in New York City," *American Journal of Public Health*, 105, 3, e81–e87 at e84, PBHN000004332–8; "In Conversation With... Leah Binder, MA, MGA," *Agency for Healthcare Research and Quality*, April 1 2014, <https://psnet.ahrq.gov/perspective/conversation-leah-binder-ma-mga>, PBHN000003777–88.

³⁸ Figlio, D. N. and M. E. Lucas (2004), "What's in a Grade? School Report Cards and the Housing Market," *American Economic Review*, 94, 3, 591–604 at p. 598, PBHN000003599–613.

³⁹ McCarthy, I., et al. (2022), "Online Reviews and Hospital Choices," Economic Analysis Group, Antitrust Division, U.S. Department of Justice, 1–78 at p. 2, PBHN000004010–87. Yelp presents users with star ratings for hospitals which are an average of the prior user reviews, rounded to the nearest half-star. The study controls for hospital quality by including hospital characteristics including "total bed, nurse, and physician counts; indicators for teaching hospital status and system membership; payer mix [; and] ... hospital readmission rates." The authors additionally analyzed the effect of ratings on the price of hospital

- A nationally representative survey of parents published in 2014 regarding choice of children’s physicians found that “about three-quarters (74%) of parents were aware of physician-rating sites, and about one-quarter (28%) had used them to select a primary care physician for their children.” Among respondents who sought ratings online, 30% stated they had chosen not to visit a physician due to negative ratings, and 30% stated they had selected their children’s physician based on positive ratings or reviews.⁴⁰
- A 2023 survey experiment examining the effect of star ratings on hospital choice found that respondents were willing to pay \$1,698 more, or travel 185 miles further, on average, for a hospital with a 1-star-higher rating on clinical outcomes and \$615 more on average or travel 62 miles further for a hospital with a 1-star-higher rating on safety outcomes.⁴¹ Additionally, the study found that “Medicare beneficiaries were willing to pay more or travel further to move from 1- to 2-star hospitals than from a 4- to 5-star hospital.”⁴²
- A 2009 study examining the effect of the U.S. News and World Report hospital rankings on consumer choice found that a one spot drop in ranking was associated with a 6 to 7 percent decline in patient volume and revenue.⁴³ The author concluded that “[w]hile it can be argued whether changes in these rankings reflect true changes in hospital quality, at the very least, consumers are willing to respond to changes in *perceived* hospital quality.”⁴⁴
- In the context of demand for physician appointments, a 2013 study of ratings and appointments data from ZocDoc found that a half star drop in ratings (on a 1 to 5 scale) was associated with a 10% average decrease in the likelihood that a doctor would fill an appointment.⁴⁵
- A 2018 survey experiment found that a physician rated two stars instead of four in government clinical ratings or commercial non-clinical ratings had significantly lower odds of being chosen.⁴⁶

services, which they defined as the average non-Medicare insurance payment to a hospital for an inpatient stay. According to the authors, the price of hospital services reflects patients’ hospital choice so that a higher price is indicative of greater demand for the services of the hospital. The authors found that hospitals lacking online reviews were associated with higher prices compared to hospitals with negative reviews. See McCarthy, I., et al. (2022), “Online Reviews and Hospital Choices,” Economic Analysis Group, Antitrust Division, U.S. Department of Justice, 1–78 at pp. 3, 21, 41, 47, PBHN000004010–87.

⁴⁰ Hanauer, D. A., et al. (2014) “Parental Awareness and Use of Online Physician Rating Sites,” *Pediatrics*, 134, 4, e966–e975 at pp. e966, e968–e969, PBHN000003736–45.

⁴¹ Trenaman, L., et al. (2023), “What is a Star Worth to Medicare Beneficiaries? A Discrete Choice Experiment of Hospital Quality Ratings,” *Health Affairs Scholar*, 2, 1, 1–7 at p. 4.

⁴² Trenaman, L., et al. (2023), “What is a Star Worth to Medicare Beneficiaries? A Discrete Choice Experiment of Hospital Quality Ratings,” *Health Affairs Scholar*, 2, 1, 1–7 at p. 5.

⁴³ Hospital rankings are based on U.S. News and World Report’s rank of U.S. hospitals. The study controls for hospital quality by incorporating the effect of a continuous quality score in the model. Pope, D. G. (2009), “Reacting to Rankings: Evidence from ‘America’s Best Hospitals’” *Journal of Health Economics*, 28, 6, 1154–1165 at pp. 1154–1155, 1163, PBHN000004101–12.

⁴⁴ Emphasis added. Pope, D. G. (2009), “Reacting to Rankings: Evidence from ‘America’s Best Hospitals’” *Journal of Health Economics*, 28, 6, 1154–1165 at p. 1164, PBHN000004101–12.

⁴⁵ Luca, M., and S. Vats (2013), “Digitizing Doctor Demand: The Impact of Online Reviews on Doctor Choice,” American Economic Association Working Paper, p. 3, PBHN000003962–4009.

⁴⁶ Yaraghi, N., et al. (2018), “How Online Quality Ratings Influence Patients’ Choice of Medical Providers: Controlled Experimental Survey Study,” *Journal of Medical Internet Research*, 20, 3, 1–14 at pp. 1, 6, PBHN000004339–52.

31. The above examples from the academic literature demonstrate that consumers are less likely—and often much less likely—to choose hospitals and physicians with lower ratings. These studies also show that consumers are even willing to incur the extra cost of traveling farther away from their residence in order to visit higher ranked and rated hospitals. These findings demonstrate the significant influence of third-party ratings on consumers’ healthcare choices.

32. Further, in a study publicized on leapfroggroup.org,⁴⁷ researchers examined the effect of safety and cost information on consumers’ hospital choices in a discrete choice survey experiment, with safety information represented as letter grades modeled after TLG’s Hospital Safety Grades.⁴⁸ In each question, respondents were asked to choose between hospitals 1 and 2, where hospital 2 was always rated less safe but could be higher or lower cost than hospital 1.⁴⁹ Results indicated that consumers “chose safer hospitals in 97% of cost and safety scenarios,” and that “larger differences in safety resulted in greater preference [for the facility that was rated as safer].”⁵⁰

B. Hospital Choice is a Complex Decision Which Increases Reliance on Heuristic Cues like TLG’s Hospital Safety Grades

33. Choosing a hospital is often a complex decision. It can be difficult for consumers to evaluate the variety of attributes that differentiate hospitals (e.g., providers, availability, facilities, costs, quality, safety, the ability of the hospital to meet the individual consumer’s specific needs regarding care), some or all of which consumers may consider as part of their hospital selection process.⁵¹ While reviewing, processing, and evaluating all available information would be a time-consuming and difficult process, studies show that consumers typically engage in some level of research online, where TLG’s Hospital Safety Grades are easily accessible, as they make

⁴⁷ Duke, C. C., et al. (2017), “The Effects of Hospital Safety Scores, Total Price, Out-of-Pocket Cost, and Household Income on Consumers’ Self-Reported Choice of Hospitals,” *Journal Patient Safety*, 13, 4, 192–198, PBHN000003517–23 (“Duke et al. (2017)”), which is made available by TLG at https://www.hospitalsafetygrade.org/media/file/JournalofPatientSafety_AltaurumReport.pdf; “The Altarum Institute Studies the Hospital Safety Score,” *The Leapfrog Group*, December 4, 2014, <https://www.leapfroggroup.org/news-events/altarum-institute-studies-hospital-safety-score>, PBHN000002644–50.

⁴⁸ Duke et al. (2017), pp. 192–193, PBHN000003517–23.

⁴⁹ Duke et al. (2017), p. 193, PBHN000003517–23.

⁵⁰ Duke et al. (2017), pp. 192, 197, PBHN000003517–23.

⁵¹ “Consumers in Health Care: The Burden of Choice,” *California HealthCare Foundation*, October 2005, <https://www.chcf.org/wp-content/uploads/2017/12/PDF-ConsumersInHealthCareBurdenChoice.pdf>, pp. 8–9, 26, PBHN000003417–50; “Consumer Choice in U.S. Health Care: Using Insights from the Past to Inform the Way Forward,” *The Commonwealth Fund*, November 30, 2021, <https://www.commonwealthfund.org/publications/fund-reports/2021/nov/consumer-choice-us-health-care-using-insights-from-past>, PBHN000003391–404; Kahn et al. (1997), p. 362, PBHN000003833–48.

healthcare decisions. For example, a 2019 U.S. nationwide survey found that 49% of patients used a review site or content site (e.g., Yelp or WebMD) to search for a provider.⁵² Similarly, a survey conducted by McKinsey in 2019 found that 37% of respondents searched online or used an app to “learn[] about the quality of a clinician or facility.”⁵³

34. TLG publicizes its Hospital Safety Grades widely, in public press releases, through coverage in print and television media, and some insurers present TLG’s Hospital Safety Grades to consumers, making it more likely consumers will see them during their research. For example, TLG widely publicized its Fall 2024 Hospital Safety Grades, including by issuing a press statement announcing their release.⁵⁴ According to TLG’s quarterly media report, the Fall 2024 Hospital Safety Grades generated “772 online articles from 435 different publications with a reach of 11.2 billion,” including in prominent outlets as the *Chicago Tribune*.⁵⁵ Of note, Florida, where Plaintiff Hospitals are all located, was the state with the highest number of articles covering the Fall 2024 Safety Grades.⁵⁶ TLG similarly publicized its Spring 2025 Hospital Safety Grades, issuing a press release on May 1, 2025⁵⁷ and generating “774 online articles from 486 different publications with a reach of ~59 million.”⁵⁸ Plaintiff Hospitals’ Safety Grades were covered in several news articles at the time of TLG’s press releases.⁵⁹ Similarly, TLG states that its Hospital Safety Grades are used by “dozens of national and regional health plans ... to educate their users on the importance of choosing a safer hospital.”⁶⁰

⁵² “Customer Experience Trends in Healthcare 2020,” *Doctor.com*, <https://cms.doctor.com/wp-content/uploads/2020/03/xtrends2020-report-final.pdf>, PBHN000003451–76.

⁵³ “Consumer Decision Making in Healthcare: The Role of Information Transparency,” *McKinsey & Company*, July 2020, [https://www.mckinsey.com/~/media/McKinsey/Industries/Healthcare/Systems and Services/Our Insights/Consumer decision making in healthcare/Consumer-decision-making-in-healthcare-The-role-of-information-transparency.pdf](https://www.mckinsey.com/~/media/McKinsey/Industries/Healthcare/Systems%20and%20Services/Our%20Insights/Consumer%20decision%20making%20in%20healthcare/The%20role%20of%20information%20transparency.pdf), PBHN000003405–16.

⁵⁴ “Fall 2024 Leapfrog Hospital Safety Grade Shows Significant Progress in Patient Safety Nationwide,” *The Leapfrog Group*, November 15, 2024, <https://www.leapfroggroup.org/news-events/fall-2024-leapfrog-hospital-safety-grade-shows-significant-progress-patient-safety>, PBHN000002416–7.

⁵⁵ LEAPFROG000000065–85 at LEAPFROG000000070–77.

⁵⁶ LEAPFROG000000065–85 at LEAPFROG000000070.

⁵⁷ “Leapfrog’s Spring 2025 Safety Grades Are In — New Trend Data Shows One in Eight Hospitals Sustained an ‘A’ for More Than Two Years,” *The Leapfrog Group*, May 1, 2025, <https://www.leapfroggroup.org/news-events/leapfrog%E2%80%99s-spring-2025-safety-grades-are-%E2%80%94new-trend-data-shows-one-eight-hospitals>, PBHN000002523–4.

⁵⁸ LEAPFROG000000122–40 at LEAPFROG000000126.

⁵⁹ See, e.g., “Tenet Hospitals at Bottom of Local Safety Grades,” *Stet News*, December 9, 2024, <https://stetnews.org/2024/12/09/tenet-hospitals-at-bottom-of-local-safety-grades/>, PBHN000002571–5; “Where Are Leapfrog’s 13 ‘F’ Hospitals,” *Beckers Hospital Review*, November 15, 2024, <https://www.beckershospitalreview.com/rankings-and-ratings/where-are-leapfrogs-14-f-hospitals.html>, PBHN000004328–31; “What Are the Best And Worst South Florida Hospitals for Patient Safety? See the Rankings,” *Miami Herald*, January 16, 2025, <https://www.miamiherald.com/news/health-care/article297048999.html>, PBHN000004319–27.

⁶⁰ “Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.leapfroggroup.org/data-users/leapfrog-hospital-safety-grade>.

35. TLG has even publicized Plaintiff Hospitals' grades in the context of this lawsuit. For example, in a TLG website post on May 2, 2025 about the lawsuit, TLG listed each hospital and its Hospital Safety Grade at the top of the article (e.g., "Delray Medical Center (Hospital Safety Grade: F)").⁶¹ Similarly, on June 30, 2025, TLG's President and CEO, Leah Binder, published an op-ed in *The Palm Beach Post* in which she stated, "the five [Plaintiff] [H]ospitals earn exceptionally poor grades: three Ds and two Fs."⁶²

36. When faced with complex decisions, like choosing a hospital, consumers often rely on heuristics, or "decisional shortcuts," to make choices.⁶³ Heuristics are strategies that can "provide[] an efficient means of finding an answer but cannot guarantee a correct outcome."⁶⁴ For example, a simple heuristic that people might use choosing between apartments is to first eliminate options with a high noise level, then choose the cheapest among the remaining options.⁶⁵

37. Consumers using heuristic decision-making strategies often place more weight on or rely on information that is simple to process, easy to recall, or easy to find, like TLG's Hospital Safety Grades.⁶⁶ TLG's Hospital Safety Grades and TLG's scores for each individual measure are presented in evaluative categories (e.g., letter grades, red/yellow/green dial graphics), and as explained in Section V.B, research has shown that presenting information in such evaluative categories can make it easier for consumers to comprehend the information, facilitate comparisons across options, and increase the weight of that information in decision-making.⁶⁷ Indeed, TLG's own website states that "[o]ne of the most significant problems with today's health care system is

⁶¹ Opposition to the Motion to Dismiss, Exhibit D, p. 2 (citing "Follow-Up Statement from Leapfrog President and CEO Leah Binder on Tenet Healthcare Hospitals' Lawsuit to Suppress Poor Safety Grade Performance," *The Leapfrog Group*, May 2, 2025, <https://www.leapfroggroup.org/news-events/follow-statement-leapfrog-president-and-ceo-leah-binder-tenet-healthcare-hospitals%E2%80%99>), PBHN000002638–40.

⁶² Opposition to the Motion to Dismiss, Exhibit B, p. 2 (citing "Leapfrog Gave Delray Medical an 'F' Grade. It Can Do Better," *Palm Beach Post*, June 30, 2025, <https://www.palmbeachpost.com/story/opinion/columns/your-voice/2025/06/30/leapfrog-gave-delray-medical-an-f-grade-it-can-do-better/84355159007/>), PBHN000003082–4.

⁶³ Blumenthal-Barby, J. and H. Krieger (2015), "Cognitive Biases and Heuristics in Medical Decision Making: A Critical Review Using a Systematic Search Strategy," *Medical Decision-Making*, 35, 539–557 at pp. 539, 542–543, 545, PBHN000003334–52; Kahn et al. (1997), pp. 363, 365–366, PBHN000003833–48.

⁶⁴ "APA Dictionary of Psychology," *American Psychological Association*, <https://dictionary.apa.org/heuristic>, PBHN000003155–7.

⁶⁵ Svenson, O. (1979), "Process Descriptions of Decision Making," *Organizational Behavior and Human Performance*, 23, 86–112 at pp. 104–105, PBHN000004198–224.

⁶⁶ See, e.g., Tversky, A. and D. Kahneman (1974), "Judgment Under Uncertainty: Heuristics and Biases," *Science*, 185, 4157, 1124–1131 at pp. 1124, 1126–1128, PBHN000004272–9; Shah, A. K. and D. M. Oppenheimer (2007), "Easy Does It: The Role of Fluency in Cue Weighting," *Judgment and Decision Making*, 2, 6, 371–379 at pp. 371, 372, 374.

⁶⁷ Peters et al. (2009), pp. 214, 224–225; Kurtzman, E. and J. Green (2016) "Effective Presentation of Health Care Performance Information for Consumer Decision Making: A Systematic Review," *Patient Education and Counseling*, 99, 36–43 at p. 41, PBHN000003925–32.

the failure to make safety and quality information available to the public. ... The purpose of the Leapfrog Hospital Safety Grade is to bring this information to light in a way that is easy for you—the consumer—to use. ... Our letter grade scoring system allows consumers to quickly assess the safety of their local hospital, and choose the safest hospital to seek care.”⁶⁸

38. Consequently, consumers using heuristic decision-making strategies may rely on TLG’s Hospital Safety Grades as a key input into their hospital choice. Indeed, a 2021 study assessed the factors that affected consumers’ preferences in hospital choices, using both focus group interviews and a survey. In the focus group of consumers, “hospital reputation or ranking” was among the “[f]actors that patients most frequently identified as important drivers,” and in the survey, the Hospital’s ranking on a ratings website was considered “Very Important” or “Important” by nearly one-third of respondents.⁶⁹ This study underscores the role that simplistic heuristics often play in consumers’ hospital selection process.

39. As an example of how TLG’s Hospital Safety Grades may be used in consumers’ decision-making, some studies have documented a “lexicographic heuristic,” where consumers decide which aspect, feature, or piece of information about available options is most important to them and select the option that performs best based on it. If there are ties, the consumer then uses the second most important piece of information, and so on.⁷⁰ A consumer using such a decision-making strategy in this context may use a TLG Hospital Safety Grade as an initial criterion, choosing the hospital that scores the best or eliminating hospitals with low or failing Hospital Safety Grades. This decision-making strategy would be facilitated by the “search” feature on hospitalsafetygrade.org, in which consumers can search for hospitals in their zip code or city.⁷¹ On the “Search Results” page, TLG presents each hospital’s Safety Grade directly next to the hospital name, as shown in Exhibit 2. In such a setting, a consumer using a lexicographic heuristic could use TLG’s Hospital Safety Grades to narrow the set of hospitals for which they want to find

⁶⁸ Plaintiffs’ Motion for a Preliminary Injunction and Motion for Expedited Discovery, or, in the Alternative for an Expedited Trial and Incorporated Memorandum of Law, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526-DMM, May 17, 2025 (“Motion for Preliminary Injunction”), Exhibit 6, p. 2, (citing “Why the Hospital Safety Grade Works,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/why-the-hospital-safety-grade-works>), PBHN000003079–81.

⁶⁹ Ellis, R., et al. (2020), “National Evaluation of Patient Preferences in Selecting Hospitals and Healthcare Providers,” *Medical Care*, 58, 10, 867–873 at p. 870, Table 2, PBHN000003555–61.

⁷⁰ Shah, A. K. and D. M. Oppenheimer (2008), “Heuristics Made Easy: An Effort-Reduction Framework,” *Psychological Bulletin*, 134, 2, 207–222 at 209.

⁷¹ LEAPFROG00000032–48 at LEAPFROG00000044.

additional information. According to TLG’s Q4 2024 Quarterly Media Report, the Search Results page was one of the most visited pages on hospitalsafetygrade.org.⁷²

Exhibit 2 Example of a Search Results Page on hospitalsafetygrade.org

How Safe is Your Hospital?

Search By City/State

3 Recent Searches

Hospital Matches
31 hospitals matching Delray Beach, FL

List Map Sort by Distance

This Hospital's Grade **Baptist Health Bethesda Hospital East**
2815 S. Seacrest Boulevard
Boynton Beach, FL 33435-7995
[View the full Score](#)

This Hospital's Grade **Delray Medical Center**
5352 Linton Boulevard
Delray Beach, FL 33484-6580
[View the full Score](#)

This Hospital's Grade **Baptist Health Boca Raton Regional Hospital**
800 Meadows Road
Boca Raton, FL 33486-2368
[View the full Score](#)

Source: “Hospital Matches: Delray Beach, FL,” *The Leapfrog Group*,
https://www.hospitalsafetygrade.org/search?findBy=city&zip_code=&city=Delray+Beach&state_prov=FL

Note: This exhibit displays an excerpt of the Search Results Page when searching for hospitals in Delray Beach, FL.

40. As another example, consumers may use an “affect heuristic,” in which they make such decisions based on their emotions or feelings about different available options.⁷³ Low or failing TLG Hospital Safety Grades are likely to evoke negative emotions from consumers, as I will discuss in the next section, and, thus, are likely to discourage consumers from choosing Plaintiff Hospitals.

⁷² LEAPFROG000000065–85 at LEAPFROG000000085.

⁷³ Kahn et al. (1997), p. 367, PBHN000003833–48; Blumenthal-Barby, J. and H. Krieger (2015), “Cognitive Biases and Heuristics in Medical Decision Making: A Critical Review Using a Systematic Search Strategy,” *Medical Decision-Making*, 539–557, Table 2, PBHN000003334–52.

C. “D” or “F” TLG Hospital Safety Grades Likely Evoke Negative Emotions about Plaintiff Hospitals, Which Can Lead Consumers to Be Less Likely to Seek Out Other, Potentially Positive Information about Plaintiff Hospitals

41. Consumers who view low or failing TLG Hospital Safety Grades are likely to experience negative emotions, which can lead them to disregard other, positive or contradictory information about the graded hospital. TLG’s Hospital Safety Grades purport to accurately measure hospital safety. Safety is not only an important factor in consumers’ healthcare decision-making, but research has also shown that when a product or service that consumers expect to be safe causes harm, they can experience strong negative emotions, like betrayal.⁷⁴ This can cause consumers to not seek out and to disregard other information about the hospital, including information that may contradict TLG’s low or failing Hospital Safety Grade.

42. TLG’s hospitalsafetygrades.org repeatedly states that TLG’s Hospital Safety Grades measure patient safety and quality of care. For example:

- On the page “About the Grade,” TLG states that “Leapfrog Hospital Safety Grades ... [are] the gold standard measure of patient safety” and “represent[] a hospital’s overall performance in keeping patients safe from preventable harm and medical errors.”⁷⁵
- On the page “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” TLG states that “[t]he Leapfrog Hospital Safety Grade is an ‘A,’ ‘B,’ ‘C,’ ‘D,’ or ‘F’ assigned to general hospitals in the U.S., the only such rating program focused exclusively on how safe they are for their patients.”⁷⁶
- On the page “How to Use the Grade,” TLG states that “not all hospitals prioritize their patient’s safety above all else. You deserve to know which hospitals do the best at protecting their patients from harm. That’s why we developed the Leapfrog Hospital Safety Grade. ... The Safety Grade rates hospitals on the very basics of medical care, such as handwashing, entering prescriptions through a computer, and the availability of highly-trained nurses.”⁷⁷
- On the page “Choosing the Best Hospital,” TLG states that “[y]our first step in finding the best care for yourself and your family is finding a safer hospital. Use the Leapfrog

⁷⁴ Koehler, J. J. and A. D. Gershoff (2003), “Betrayal Aversion: When Agents of Protection Become Agents of Harm,” *Organizational Behavior and Human Decision Processes*, 90, 244–261 at pp. 250–252, PBHN000003907–24; Gershoff, A. D. and J. J. Koehler (2011), “Safety First? The Role of Emotion in Safety Product Betrayal Aversion,” *The Journal of Consumer Research*, 38, 140–150 at pp. 143–144, PBHN000003674–85.

⁷⁵ Motion to Dismiss, Exhibit 4, p. 2 (citing “About the Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/about-the-grade>), PBHN000002619–25.

⁷⁶ Motion to Dismiss, Exhibit 3, p. 2 (citing “Frequently Asked Questions About the Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

⁷⁷ Motion for Preliminary Injunction, Exhibit 15, pp. 2–3 (citing “How to Use the Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/how-to-use-the-grade>), PBHN000003070–5.

Hospital Safety Grade search tool to find the safest hospital in your area, preferably one with an ‘A’ grade.”⁷⁸

43. Research has found that quality and safety are important attributes in healthcare decision-making.⁷⁹ A report by the Commonwealth Fund (a non-profit healthcare policy research group) found that “research supports the view that patients highly value information on health care ... quality,” and work on consumer healthcare decision-making observed that “[c]onsumer safety is a prerequisite for overall effectiveness.”⁸⁰ Consistent with these findings, in the study publicized on leapfroggroup.org described in Section VI.A, respondents faced with hypothetical choices between hospitals with different costs and safety scores were found to choose safer hospitals in 97% of cost and safety scenarios. The researchers concluded that “[c]onsumers perceived safety and differences in safety as important in their preferences ... very few respondents would sacrifice large differences in safety to save money.”⁸¹ Indeed, hospitalsafetygrade.org frames safety as a fundamental aspect of healthcare, stating “[a] hospital may have the best surgeons and greatest technology in the world, but unless it is preventing infections and eliminating errors, it is not delivering on a very basic premise: ensuring the safety of you and your loved ones.”⁸²

44. When consumers are informed that a product or service for which they expect safety actually *causes* harm, they can experience strong negative emotions, like feeling betrayed. Specifically, when the betrayal relates to a product or service involving “a duty or promise to protect,” the negative emotion is greater compared to that experienced from “identical bad acts that do not violate a duty or promise to protect.”⁸³ In safety-related environments, like healthcare,

⁷⁸ Motion to Dismiss, Exhibit 7, pp. 2–3 (citing “Choosing the Best Hospital,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/choosing-the-best-hospital>), PBHN000002626–8.

⁷⁹ Moore, G., et al. (2018), “Chapter 5: The Six E’s of Consumer Choice” in *Choice Matters: How Healthcare Consumers Make Decisions (and Why Clinicians and Managers Should Care)*, (Oxford, UK: Oxford University Press) pp. 148–149; Trenaman, L., et al. (2023), “What is a Star Worth to Medicare Beneficiaries? A Discrete Choice Experiment of Hospital Quality Ratings,” *Health Affairs Scholar*, 2, 1, 1–7 at pp. 3–4.

⁸⁰ “Consumer Choice in U.S. Health Care: Using Insights from the Past to Inform the Way Forward,” *The Commonwealth Fund*, November 30, 2021, <https://www.commonwealthfund.org/publications/fund-reports/2021/nov/consumer-choice-us-health-care-using-insights-from-past>, PBHN000003391–404; Moore, G., et al. (2018), “Chapter 5: The Six E’s of Consumer Choice” in *Choice Matters: How Healthcare Consumers Make Decisions (and Why Clinicians and Managers Should Care)*, (Oxford, UK: Oxford University Press) p. 149.

⁸¹ Duke et al. (2017), pp. 192, 197, PBHN000003517–23.

⁸² Motion for Preliminary Injunction, Exhibit 6, pp. 2–3, cited as (“Why the Hospital Safety Grade Works,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/why-the-hospital-safety-grade-works>), PBHN000003079–81.

⁸³ Koehler, J. J. and A. D. Gershoff (2003), “Betrayal Aversion: When Agents of Protection Become Agents of Harm,” *Organizational Behavior and Human Decision Processes*, 90, 244–261 at p. 244, PBHN000003907–24.

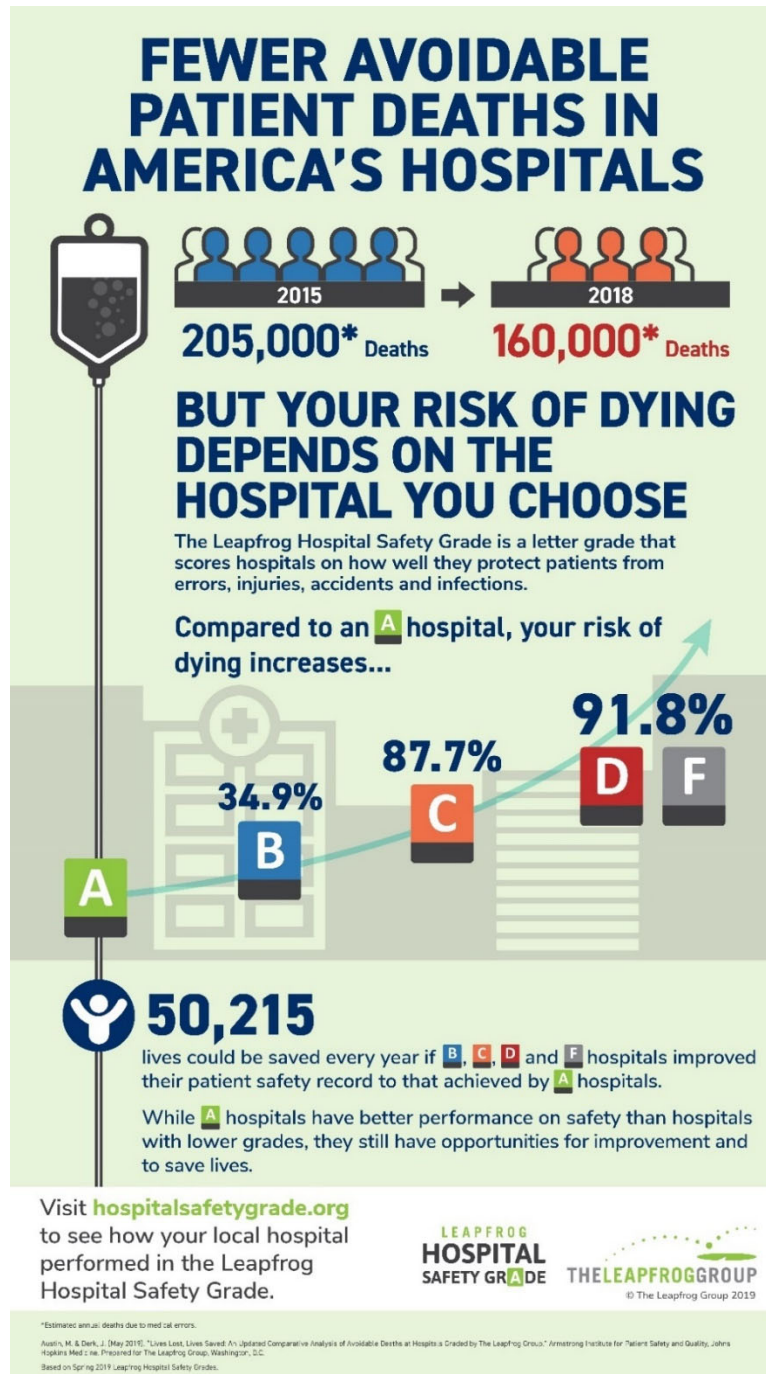
consumers are likely to experience these negative emotions even when they are faced with *the risk of harm*, and need not necessarily experience the actual harm.⁸⁴

45. Content on hospitalsafetygrade.org emphasizes both the risk of harm from choosing a “D” or “F” rated hospital and, for the imputed measures, the risk of choosing a hospital that is rated poorly on that measure. For example, on the page “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” TLG states that “It is critical to monitor safety before choosing a hospital. Preventable medical errors, accidents, injuries and infections in hospitals kill upwards of 200,000 people every year, the third leading cause of death in the United States” and “Johns Hopkins Medicine researchers estimate that patients are twice as likely to die of a preventable problem at a ‘C,’ ‘D,’ or ‘F’ hospital than an ‘A’ hospital, and over 50,000 lives would be saved if all hospitals performed the way A hospitals did.”⁸⁵ In the same vein, Exhibit 3 is an infographic from hospitalsafetygrades.org, which claims that a patient’s risk of dying increases by 90% when she chooses a “D” or “F” rated hospital instead of an “A” rated hospital.

⁸⁴ Gershoff, A. D. and J. J. Koehler (2011), “Safety First? The Role of Emotion in Safety Product Betrayal Aversion,” *The Journal of Consumer Research* 38, 140–150 at pp. 143, 145, PBHN000003674–85.

⁸⁵ Motion to Dismiss, Exhibit 3, p. 3 (citing “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

Exhibit 3 Example of Content on hospitalsafetygrade.org that Emphasizes Risk of Harm



Source: "Lives Lost and Lives Saved," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/LivesLost>

Note: This exhibit shows an infographic displayed on-screen when a user navigates to the "Lives Lost and Lives Saved" page on hospitalsafetygrade.org.

46. TLG makes similar statements in content on leapfroggroup.org. For example, TLG provides “Patient Toolkits,” which it describes as “toolkits ... to empower patients with the knowledge and resources to make informed decisions about [their] medical care.”⁸⁶ In its toolkit titled, “Leapfrog Hospital Safety Grade Explained Toolkit,” under a heading “Why are Hospital Safety Grades Important?,” TLG includes statements like “[e]very year, one out of 31 patients develop an infection while in the hospital, and a Medicare patient has a one in four chance of experience, injury, harm or death when admitted into a hospital.”⁸⁷

47. Similarly, on TLG’s Hospital Safety Grade Page, a description of each measure is shown alongside the hospital’s score on that measure, as shown in Exhibit 4. For three of the four imputed measures at issue in this matter, the description includes language related to harm, as described below.⁸⁸ Thus, for each Plaintiff Hospital, TLG’s Hospital Safety Grade page displays harm-related language directly alongside a low imputed score on these measures.

- **Doctors order medications through a computer:** “Good CPOE [Computerized Physician Order Entry] systems alert the doctor if they try to order a medication *that could cause harm*...”⁸⁹
- **Specially trained doctors care for ICU patients:** “There are *higher death rates* in hospitals where ICU patients are not cared for by intensivists.”⁹⁰
- **Handwashing:** “When hospital staff does not carefully wash their hands, they can spread germs from one patient to another and cause someone to become *seriously ill*.”⁹¹

⁸⁶ “Judie Burrows Education Institute Patient Toolkits,” *The Leapfrog Group*, <https://www.leapfroggroup.org/judie-burrows-education-institute-patient-toolkits>.

⁸⁷ “Leapfrog Hospital Safety Grades Explained,” *The Leapfrog Group*, <https://www.leapfroggroup.org/sites/default/files/Files/Leapfrog%20Patient%20Toolkits%20%281%29.pdf>.

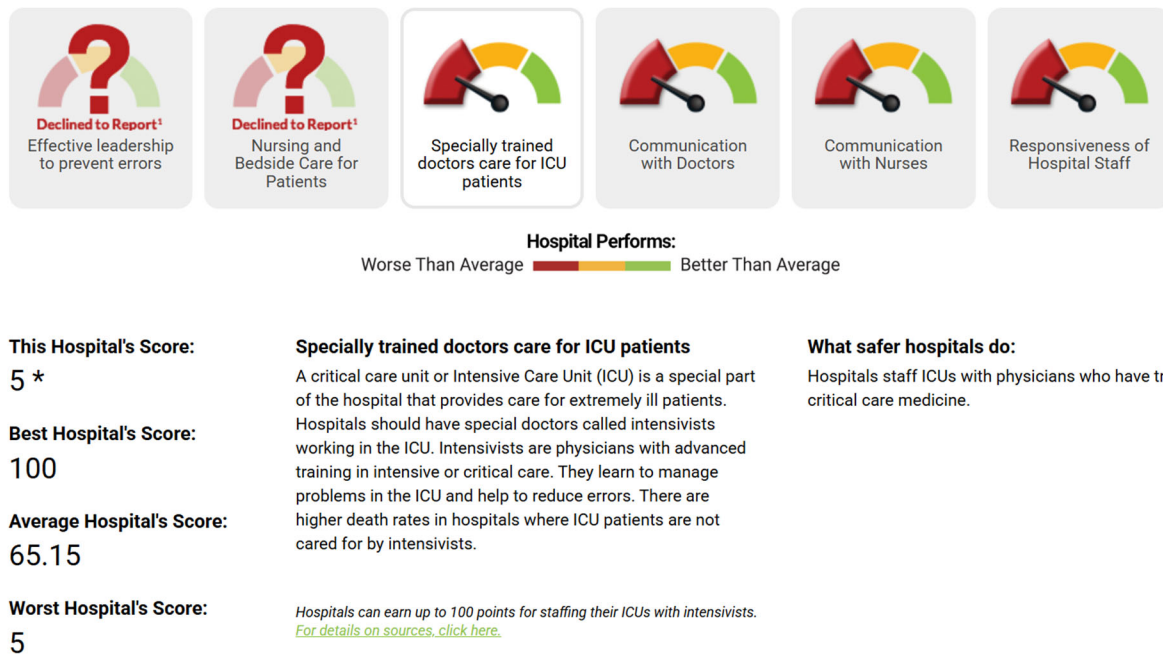
⁸⁸ The fourth measure, “Safe medication administration,” discusses “the risk that a hospital accidentally gives the wrong medication to a patient.” *See, e.g., “Palm Beach Gardens Medical Center,” The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>.

⁸⁹ Emphasis added. *See, e.g., “Palm Beach Gardens Medical Center,” The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>.

⁹⁰ Emphasis added. *See, e.g., “Palm Beach Gardens Medical Center,” The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>.

⁹¹ Emphasis added. *See, e.g., “Palm Beach Gardens Medical Center,” The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>.

Exhibit 4 Example of Description of the ICU Physician Staffing Measure on hospitalsafetygrade.org



Source: "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays an excerpt of the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the "Doctors, Nurses & Hospital Staff" tab and "Specially trained doctors care for ICU patients" measure.

48. While it is possible that the impact of low or failing TLG Hospital Safety Grades on a consumer's hospital choice may be reduced if the consumer is exposed to other, positive information about the hospitals she is considering, research has found that when consumers are exposed to negative information about a product, they are less likely to continue searching for additional information about it.⁹² Negative information about a product also leads consumers to seek out information about substitutes.⁹³ Further, studies show that when participants experience negative emotions, they are more likely to disregard additional information they receive.⁹⁴

⁹² Varga, M. and P. Albuquerque (2023), "The Impact of Negative Reviews on Online Search and Purchase Decisions," *Journal of Marketing Research*, 61, 5, 803–820 at p. 813, PBHN000004293–311.

⁹³ Varga, M. and P. Albuquerque (2023), "The Impact of Negative Reviews on Online Search and Purchase Decisions," *Journal of Marketing Research*, 61, 5, 803–820, at p. 813, PBHN000004293–311.

⁹⁴ Keller, P. A. (1999), "Converting the Unconverted: The Effect of Inclination and Opportunity to Discount Health-Related Fear Appeals," *Journal of Applied Psychology*, 84, 3, 403–415 at p. 413.

49. Consequently, when exposed to a “D” or “F” TLG Hospital Safety Grade, consumers are likely to experience negative emotions, like betrayal, and might limit their search for additional information about those hospitals, including positive information that could contradict a low or failing Hospital Safety Grade.

D. TLG Presents the Four Imputed Measures as Fundamental Aspects of Medical Care and Frames its Hospital Safety Grades as Essential Inputs into Consumers’ Hospital Choices

50. Consistent with the premise that Hospital Safety Grades can influence consumers’ hospital choices, TLG itself emphasizes the importance of using them in making such decisions. On [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org), TLG repeatedly stresses that several specific imputed measures are determinative of hospital safety, the potential consequences of choosing an unsafe hospital, and the importance of using TLG’s Hospital Safety Grades to choose the safest hospital. Consequently, consumers who view this content, and view the low or failing TLG Hospital Safety Grades for Plaintiff Hospitals, may be persuaded to avoid Plaintiff Hospitals.

51. Specific to the imputed measures, [hospitalsafetygrades.org](https://www.hospitalsafetygrades.org) frames some as fundamental aspects of medical care and encourages consumers to weigh these measures more heavily when making their decisions. For example:

- **Handwashing:** TLG states that “[t]he Safety Grade rates hospitals on the very basics of medical care, such as handwashing, entering prescriptions through a computer...”⁹⁵ and lists Handwashing as one of three “most important” measures⁹⁶
- **Specially trained doctors care for ICU patients:** “If you’re concerned about a seriously-ill parent or family member, you can look at ICU staffing protocols and how the hospital uses computerized prescribing and bar-code technology to keep patients safe from medication errors.”⁹⁷

52. More broadly, multiple pages on [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org) emphasize the importance of hospital choice in making healthcare decisions and, consequently, the use of TLG’s Hospital

⁹⁵ Motion for Preliminary Injunction, Exhibit 15, p. 3 (citing “How to Use the Grade”, *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/how-to-use-the-grade>), PBHN000003070–5.

⁹⁶ Motion for Preliminary Injunction, Exhibit 15, p. 4 (citing “How to Use the Grade”, *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/how-to-use-the-grade>), PBHN000003070–5.

⁹⁷ Motion to Dismiss, Exhibit 7, p. 3 (citing “Choosing the Best Hospital,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/choosing-the-best-hospital>), PBHN000002626–8.

Safety Grades. Specifically, the language used by TLG presents hospital choice not only as important to a consumer's safety, but as a matter of life or death. For example:

- "Your choice of hospital could be a life or death decision. Hospitals vary greatly on things like infection rates, surgical errors, and patient injuries—not to mention ER wait times, patient satisfaction, and other things we're just now starting to measure."⁹⁸
- "It is critical to monitor safety before choosing a hospital. Preventable medical errors, accidents, injuries and infections in hospitals kill upwards of 200,000 people every year, the third leading cause of death in the United States."⁹⁹
- "YOUR RISK OF DYING DEPENDS ON THE HOSPITAL YOU CHOOSE"¹⁰⁰

53. Finally, TLG's website presents TLG's Hospital Safety Grades to consumers as the primary piece of information they should use in choosing a hospital. For example:

- "When they have a choice, the Hospital Safety Grade is the first tool patients *should* use to select a hospital, because safety should come first."¹⁰¹
- "Choosing the best hospital for you doesn't have to be a daunting task—as long as you have the right tools. Your first step in finding the best care for yourself and your family is finding a safer hospital. Use the Leapfrog Hospital Safety Grade search tool to find the safest hospital in your area, preferably one with an 'A' grade."¹⁰²
- "Find a safer hospital. When you get to the list of hospital matches, look for hospitals with the highest grade. If there's more than one hospital with a good grade, then you can look at other things that are important to you."¹⁰³

54. Thus, across [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org), TLG encourages consumers to rely on both its Hospital Safety Grades and some of its imputed measures as essential inputs into their hospital choices, while conveying to consumers that their choices can be a matter of life or death.

⁹⁸ Motion to Dismiss, Exhibit 7, p. 2 (citing "Choosing the Best Hospital," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/choosing-the-best-hospital>), PBHN000002626–8.

⁹⁹ Motion to Dismiss, Exhibit 3, p. 3 (citing "Frequently Asked Questions About the Leapfrog Hospital Safety Grade," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

¹⁰⁰ Motion to Dismiss, Exhibit 6, p. 5 (citing "Lives Lost and Lives Saved," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/LivesLost>), PBHN000003004–8.

¹⁰¹ Emphasis added. Motion to Dismiss, Exhibit 3, p. 7 (citing "Frequently Asked Questions About the Leapfrog Hospital Safety Grade," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

¹⁰² Motion to Dismiss, Exhibit 7, pp. 2–3 (citing "Choosing the Best Hospital," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/choosing-the-best-hospital>), PBHN000002626–8.

¹⁰³ Transcribed from embedded video on page "Your Hospital's Safety Grade" on [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org). See "Your Hospital's Safety Grade," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade>, PBHN000004353.

VII. Future, Repeated Publications of “D” or “F” Hospital Safety Grades Would Be Expected to Have a Long-Term, Negative Impact on Perceptions of and Choice for Plaintiff Hospitals

55. The previous sections discuss how low or failing TLG Hospital Safety Grades would likely negatively impact consumers’ perceptions of, and choices for, Plaintiff Hospitals. This section discusses why the negative impacts of low or failing Hospital Safety Grades would be expected to be long-lasting, and how these impacts would be further amplified by future, repeated publications of low or failing Hospital Safety Grades.

56. TLG’s low or failing grades for Plaintiff Hospitals will likely have negative long-term effects on many consumers’ perceptions of these hospitals, as consumers who are exposed to the grades share their perceptions with others through word of mouth.¹⁰⁴ For example, one TikTok video posted by user “True Stories,” uses TLG’s Fall 2024 Hospital Safety Grades to create a list of the “worst hospital in Florida.” The video lists four of the five Plaintiff Hospitals (West Boca Medical Center, Delray Medical Center, Good Samaritan Medical Center, and Palm Beach Gardens Medical Center) as among the top five worst hospitals in Florida.¹⁰⁵ Moreover, the video explicitly cites TLG’s assessment of each hospital’s performance on different measures, including the imputed measure for “Handwashing.” As of August 6, 2025, the video had over a million views, 43,000 likes, 3,000 comments, and almost 30,000 shares.

57. Moreover, the impact of TLG’s currently published Hospital Safety Grades for Plaintiff Hospitals may be long-lasting because negative impressions can be hard to overcome. Research shows that, compared to positive impressions, negative impressions can be slower to change or fade.¹⁰⁶ For example, in one study, the researcher asked participants to write first-person sentences with friendly, neutral, or hostile words.¹⁰⁷ The sentences using hostile words resulted in a longer

¹⁰⁴ Berger, J. (2014), “Word of Mouth and Interpersonal Communication: A Review and Directions for Future Research,” *Journal of Consumer Psychology*, 24, 4, 586–607 at pp. 587, 594, PBHN000003281–302.

¹⁰⁵ “@usamap55 Video,” *TikTok*, https://www.tiktok.com/@usamap55/video/7525460573430107405?_r=1&_t=ZP-8xwM4HOacsp, PBHN000002238.

¹⁰⁶ Baumeister, R. F., et al. (2001), “Bad is Stronger than Good,” *Review of General Psychology*, 5, 4, 323–370 at pp. 323, 325, PBHN000003216–63; Sanbonmatsu D. M., et al. (2022), “Perceived Changes in Trait Attributions to Others and the Self,” *Journal of Social Psychology*, 164, 5, 1–19 at p. 1, PBHN000004131–50.

¹⁰⁷ Ikegami, T. (1993), “Positive-Negative Asymmetry of Priming Effects on Impression Formation,” *European Journal of Social Psychology*, 23, 1, 1–16 at pp. 5–6, 8, PBHN000003761–76.

lasting effect on participants' emotional states than the sentences containing friendly or neutral words.¹⁰⁸

58. Additionally, future publication of low or failing Hospital Safety Grades for Plaintiff Hospitals may cause consumers who had already been exposed to this information to see it repeatedly, and research has shown that repeated exposure can increase the persuasiveness of information. For example, research has found that, in many circumstances, the act of being repeatedly exposed to information changes the way individuals perceive that information. Repeated exposure to information can result in the belief that the information is true (known as the "illusory truth effect").¹⁰⁹ The illusory truth effect describes the tendency of repeated information to be perceived as more true. In a 2023 study, researchers showed consumers 30 health-related statements, such as "[s]ugar-sweetened beverages decrease risk of heart disease."¹¹⁰ Afterwards, the researchers showed the same consumers 60 health-related statements, of which 30 were repeated. The researchers found that "repetition of information was associated with higher perceived accuracy."¹¹¹ In other words, respondents were more likely to believe that certain health information was true the more times they viewed it. A 2009 meta-analysis found that the illusory truth effect was robust across a variety of contexts and information presentation settings, including length of time between repetitions of information as well as the presentation of information (e.g., whether the information was presented visually or auditorily).¹¹² Similarly, a meta-analysis from 2019 found that the illusory truth effect was robust to the type of information (e.g., trivia, news, and consumer opinions), how motivated individuals are to assess the truthfulness of the information, and even the presence of other information about the accuracy of the statement.¹¹³

¹⁰⁸ Ikegami, T. (1993), "Positive-Negative Asymmetry of Priming Effects on Impression Formation," *European Journal of Social Psychology*, 23, 1, 1–16 at pp. 1, 11, PBHN000003761–76; Kensinger E. A. and S. Corkin (2003), "Effect of Negative Emotional Content on Working Memory and Long-Term Memory," *Emotion*, 3, 4, 378–393 at p. 388, PBHN000003877–92; Baumeister, R. F., et al. (2001), "Bad is Stronger than Good," *Review of General Psychology*, 5, 4, 323–370 at pp. 323, 325, PBHN000003216–63.

¹⁰⁹ Vellani, V., et al. (2023), "The Illusory Truth Effect Leads to the Spread of Misinformation," *Cognition*, 236, 105421, 1–7 ("Vellani et al. (2023)") at p. 2, PBHN000004312–8; Arkes, H. R., et al. (1989), "The Generality of the Relation between Familiarity and Judged Validity," *Journal of Behavioral Decision Making*, 2, 2, 81–94 at pp. 81–82, PBHN000003167–81.

¹¹⁰ Vellani et al. (2023), Appendix A.

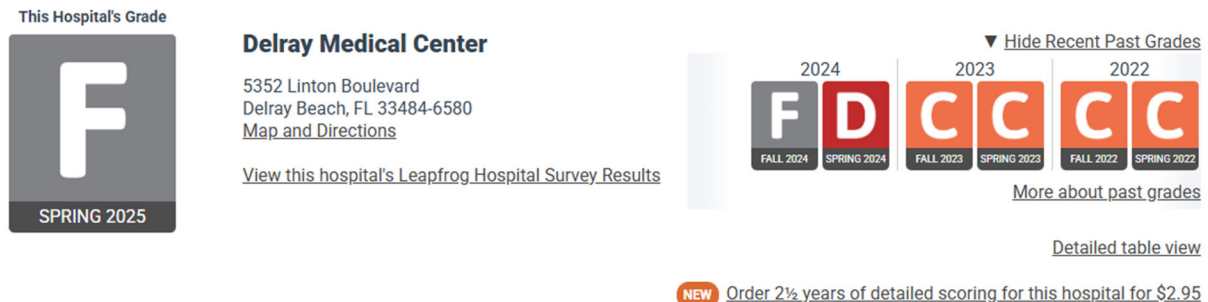
¹¹¹ Vellani et al. (2023), pp. 2, 4, PBHN000004312–8.

¹¹² Dechêne, A., et al. (2009), "The Truth About the Truth: A Meta-Analytic Review of the Truth Effect," *Personality and Social Psychology Review*, 14, 2, 238–257 at pp. 246–247, PBHN000003477–96.

¹¹³ Unkelback, C., et al. (2019), "Truth by Repetition: Explanations and Implications," *Current Directions in Psychological Science*, 28, 247–253 at p. 248, PBHN000004286–92.

59. The illusory truth effect would likely influence consumers' impressions of Plaintiff Hospitals if TLG continues to assign the hospitals low or failing Hospital Safety Grades in the future. Indeed, consumers who have already been exposed to TLG's existing "D" or "F" Hospital Safety Grades for Plaintiff Hospitals' may be exposed to future grades during future searches for information about hospitals. Moreover, on its Hospital Safety Grade Pages, TLG publishes not only the grade for the current period but also past grades, as shown in the excerpt in Exhibit 5.¹¹⁴ Thus, if TLG continues to publish low or failing Hospital Safety Grades for Plaintiff Hospitals in the future, the low or failing grades will be repeatedly published on each Plaintiff Hospital's TLG Hospital Safety Grade Page, deepening consumers' negative impressions of those hospitals.

Exhibit 5 Example of the Presentation of Past Grades on TLG's Hospital Safety Grade Pages



Source: "Delray Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/delray-medical-center>.

Note: This exhibit displays an excerpt of the Hospital Safety Grade Page for Delray Medical Center, after clicking "Show Recent Past Grades."

VIII. Many Consumers Would Be Unlikely to Understand that TLG Assigns the Minimum Score on the Imputed Measures and the Impact of this Practice on the Safety Grades TLG Assigns to Non-Participating Hospitals, Based on TLG's Imputation Disclosures

60. I understand that TLG purports to display disclosures about its imputation methodology on pages of its websites, [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org) and [leapfroggroup.org](https://www.leapfroggroup.org).¹¹⁵ Further, TLG claims that

¹¹⁴ A consumer can click "Show Recent Past Grades" on a TLG Hospital Safety Grade Page to see a hospital's past grades, as shown in Exhibits 7 and 8.

¹¹⁵ Motion to Dismiss, pp. 8–9.

the websites “encourage users to view its full grading methodology as well as the data and analysis used” and provide “full transparency in[to TLG’s] ratings programs.”¹¹⁶ However, TLG’s disclosures of its imputation methodology are unlikely to adequately inform consumers as to how it calculates its overall Hospital Safety Grade.

61. In addition to the overall letter grade shown on each Hospital Safety Grade Page, TLG also presents numeric scores and dial graphics for each measure underlying the letter grade. For the four imputed measures (i.e., “Doctors order medications through a computer,” “Safe medication administration,” “Specifically trained doctors care for ICU patients,” and “Handwashing”), TLG calculates scores using its imputation methodology, as explained in Section II.¹¹⁷ In Fall 2024, TLG changed its imputation methodology to assign the “lowest possible score” on the imputed measures for hospitals that did not participate in its survey and who did not have scores assigned in the two previous rounds of grades.¹¹⁸ TLG refers to this practice as assigning a score reflecting “Limited Achievement” on the measure. The score that is assigned can vary by imputed measure (e.g., 5 out of 100 for the measure “Specifically trained doctors care for ICU patients” and 15 out of 100 for the measure “Handwashing”), but it always represents the minimum possible score for the measure. I will refer to this practice as assigning the “minimum score” on the imputed measures.¹¹⁹

62. Plaintiffs allege that TLG fails to adequately disclose that its imputed measure scores do not represent Plaintiff Hospitals’ actual safety performance but instead their hospitals’ decisions not to respond to TLG’s hospital survey.¹²⁰ Plaintiffs also allege that TLG fails to adequately disclose the impact of its minimum score assignment on TLG’s overall “D” or “F” letter grades

¹¹⁶ Motion to Dismiss, p. 8.

¹¹⁷ The listed names are the names of the measures that appear on TLG’s Hospital Safety Grade Pages. Plaintiffs refer to these four measures as “Computerized Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hand Hygiene Score” in their Complaint. See Complaint, ¶ 51.

¹¹⁸ Complaint, ¶ 50; Motion to Dismiss, Exhibit 38, p. 3, (citing “Final Updates to the Leapfrog Hospital Safety Grade Methodology for Fall 2024,” *The Leapfrog Group*, https://www.hospitalsafetygrade.org/media/file/Fall2024HospitalSafetyGrade_FinalMethodologyChanges.pdf), PBHN000002632–7.

¹¹⁹ For each measure, TLG places hospitals in one of several performance categories, which it translates to a numeric score for the purpose of calculating the letter grade. These categories range from the highest “Achieved the Standard” (which is assigned 100 numeric score) to the lowest “Limited Achievement,” which TLG translates into a different low numeric score for each measure. See Complaint, ¶ 50; Motion to Dismiss, Exhibit 5, pp. 11–12, 14, (citing Methodology Document), PBHN000003012–40.

¹²⁰ Complaint, ¶ 52.

for Plaintiff Hospitals, which are based, in part, on scores for the imputed measures.¹²¹ I understand that TLG purports to disclose the imputation methodology in its imputation disclosures, including in notes and documentation on hospitalsafetygrade.org and leapfroggroup.org.¹²² In this section, I analyze TLG's imputation disclosures to assess the extent, if any, to which these disclosures would be expected to affect consumers' understanding of TLG's practice of assigning the minimum score on the imputed measures and the impact of this assignment on TLG's overall Hospital Safety Grades.

A. TLG Does Not Directly Disclose Information on its Practice of Assigning the Minimum Score to Non-Participating Hospitals on TLG's Hospital Safety Grade Pages

63. As background on navigating TLG's Hospital Safety Grade Pages, Exhibit 6 shows the information a consumer would see on a Hospital Safety Grade Page for Plaintiff Hospital Palm Beach Gardens Medical Center when the consumer first navigates to the page. As shown in the exhibit, on each Hospital Safety Grade Page, TLG presents both the overall letter grade for the hospital and five "tabs." When a consumer arrives on the page, the leftmost tab "Infections" is selected by default. Within each tab, there are multiple measures (e.g., "MRSA Infection," "C. diff Infection," "Infection in the blood," etc.), and TLG summarizes its scores for each measure within the tab using dial graphics (e.g., the dial pointing to green for "MRSA Infection"). When a consumer arrives on the page, the leftmost measure "MRSA Infection" is selected by default. For the selected measure, TLG then presents the hospital's numeric score on that measure (e.g., 0.278 for "MRSA Infection") as well as summaries of the "Best," "Average," and "Worst" scores across all hospitals.

¹²¹ Complaint, ¶ 52.

¹²² Motion to Dismiss, pp. 8–9. I understand TLG also purports to disclose the imputation methodology on its website leapfroggroup.org.

Exhibit 6 The Default View When a Consumer First Navigates to the TLG Hospital Safety Grade Page for Palm Beach Gardens Medical Center

The screenshot displays the Leapfrog Hospital Safety Grade website. At the top, there is a navigation bar with links: "Join Our Mailing List", "Newsroom", and "Donate Now". Below this is a header section with "LEAPFROG HOSPITAL SAFETY GRADE" and a "Back to Results" button. The main content area shows the hospital's overall grade as "F" for Spring 2025. A red arrow points to the "F" grade with the label "Overall Grade ('F')". Below the grade, there is a section for "Learn how to use the Leapfrog Hospital Safety Grade" with an icon of a person reading. A red arrow points to the "Infections" tab in the navigation bar with the label "Tab ('Infections')". Under the "Infections" tab, there are five dial graphics for different measures: MRSA Infection, C. diff Infection, Infection in the blood, Infection in the urinary tract, and Surgical site infection after surgery. A red arrow points to the MRSA Infection dial with the label "Dial Graphic for Measures". Below the dial, there is a section for "Selected Measure ('MRSA Infection')". This section includes the hospital's score (0.278), the best hospital's score (0.000), the average hospital's score (0.719), and the worst hospital's score (2.850). A red arrow points to the hospital's score with the label "Numeric Score for Selected Measure ('0.278')". Below this section, there are "Notes and Definitions" and a "LEGAL DISCLAIMER". At the bottom of the page, there is a footer section with "THE LEAPFROG GROUP" logo, a "Join Us" section with social media links, and a "Donate Now" button. The footer also contains a "By viewing this website you are agreeing to our TERMS OF USE" section and a "medical treatment that you receive from a hospital or other health care provider" section.

Source: "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the "Infections" tab and "MRSA Infection" measure, which is the default page view. The red arrows and text labels indicate different elements of the Hospital Safety Grade Page.

64. From this initial view, a consumer can then decide whether to leave the Hospital Safety Grade Page or to navigate to somewhere else on hospitalsafetygrade.org from the page. In particular, as shown in Exhibits 7 and 8, some of the places a consumer can click on include:¹²³

- “For details on sources, click here” within the description of the “MRSA Infections” measure, which takes the consumer to a table that includes the hospital’s numeric scores on each measure; the worst, average, and best scores across all hospitals; the data source for the measure; and the time period covered
- A different measure within the “Infections” tab
- A different tab and/or measure within that tab
- A link at the top of the Hospital Safety Grade Page, including:
 - “View this hospital’s Leapfrog Hospital Survey Results,” which takes the user to the hospital’s survey results on TLG’s website leapfroggroup.org
 - “Show Recent Page Grades,” which opens a dropdown of the hospital’s past six grades
 - “Detailed table view,” which takes the consumer to the same table view as the “For details on sources, click here” link
- A video, titled “Your Hospital’s Safety Grade”¹²⁴

¹²³ A consumer can also navigate to other pages on hospitalsafetygrade.org, using the dropdowns at the top of the page or the links at the very bottom of the page.

¹²⁴ When a consumer clicks on this link, they also have the option to view two other videos, with the titles “What is Patient Safety?” and “What You Can Do to Stay Safe.”

Exhibit 7 Examples of Navigation from a TLG Hospital Safety Grade Page

LEGEND

Back to Results
Goes to different tab and/or measure within that tab

Show Recent Past Grades
Goes to different measures within the "Infections" tab

Detailed table view
Goes to hospital's survey results

Learn how to use the Leapfrog Hospital Safety Grade
Goes to a TLG video titled "Your Hospital's Safety Grade"

Infections
Goes to hospital's past six grades

MRSA Infection
Goes to hospital's numeric scores for each measure

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This Hospital's Grade: **F** **SPRING 2025**

Palm Beach Gardens Medical Center
3360 Burns Road
Palm Beach Gardens, FL 33410-4304
[Map and Directions](#)

[View this hospital's Leapfrog Hospital Survey Results](#)

[Show Recent Past Grades](#)
[Detailed table view](#)

Order 2+ years of detailed scores for this hospital for \$2.95

Learn how to use the Leapfrog Hospital Safety Grade

Infections **Problems with Surgery** **Safety Problems** **Practices to Prevent Errors** **Doctors, Nurses & Hospital Staff**

MRSA Infection **C. diff Infection** **Infection in the blood** **Infection in the urinary tract** **Surgical site infection after colon surgery** **Sepsis infection after surgery**

Hospital Performs:
Worse Than Average Better Than Average

This Hospital's Score: 0.278
Best Hospital's Score: 0.000
Average Hospital's Score: 0.719
Worst Hospital's Score: 2.850

MRSA infection
Staph bacteria are common in hospitals, but Methicillin-resistant Staphylococcus aureus (MRSA) is a type of staph bacteria that is resistant to (cannot be killed by) many antibiotics. MRSA can be found in bed linens or medical equipment and can be spread if providers do not properly wash their hands between patients. MRSA can cause life-threatening bloodstream infections, pneumonia and surgical site infections.

What safer hospitals do:
Doctors and nurses should clean their hands after caring for every patient. Hospital rooms and medical equipment should be thoroughly cleaned often. Safer hospitals will also keep MRSA patients separate from other patients and require providers and visitors to wear gloves and gowns around these patients.

Notes and Definitions

- Declined to Report:** The hospital was asked to provide this information to the public, but did not.
- Not Available:** "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.
- Straight A:** The hospital has earned an A Grade for five consecutive grading rounds or more, qualifying it for recognition as a "Straight A" hospital.

LEGAL DISCLAIMER: The Leapfrog Hospital Safety Grade scores hospitals on their overall performance in keeping patients safe from preventable harm and medical errors. The grades are derived from expert analysis of publicly available data using up to 31 evidence-based, national measures of hospital safety. No specific representation is made, nor shall The Leapfrog Group be liable with respect to any individual patient's potential or actual outcome as a result of receiving services performed at any of these hospitals. Leapfrog Hospital Safety Grades cannot be reproduced without expressed written permission from The Leapfrog Group.

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- Why Use Hospital Safety Grade Works

Your Hospital's Safety Grade

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- Lives Lost and Lives Saved
- Frequently Asked Questions

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- Talking with Your Doctor About Safety
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- Data Review
- Frequently Asked Questions
- Request Archival Data Reports
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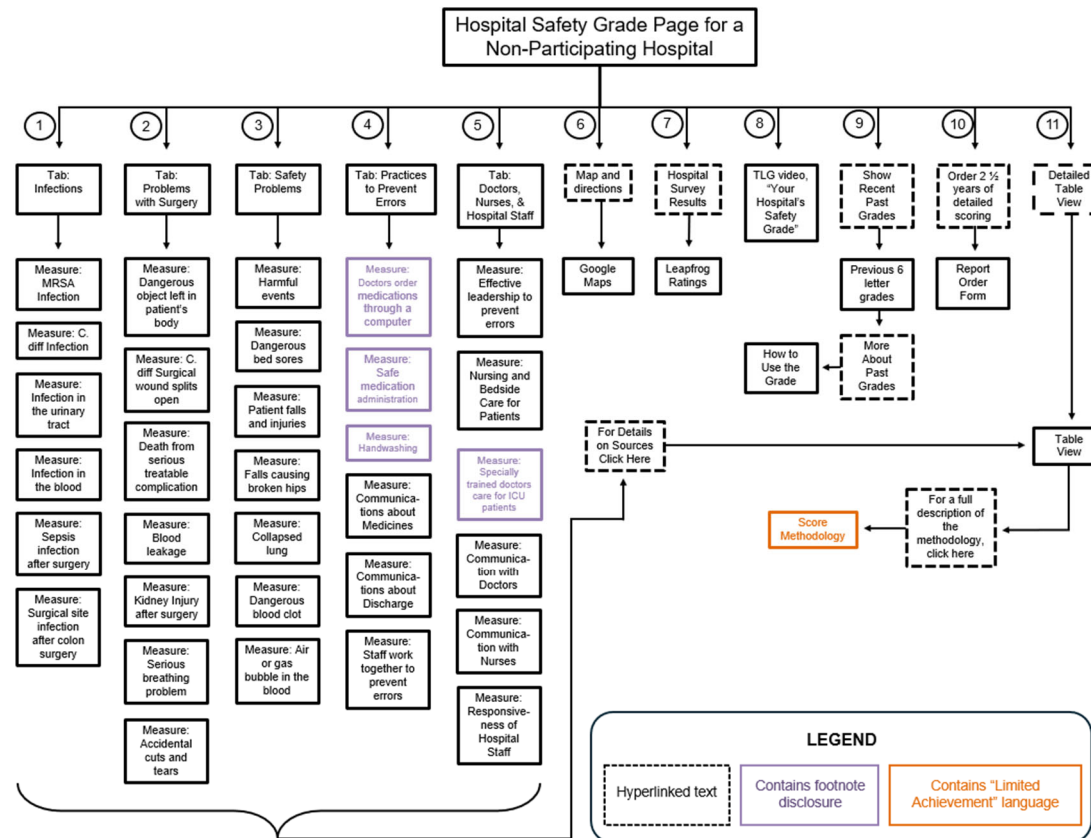
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Source: "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the "Infections" tab and "MRSA Infection" measure, which is the default page view. Color-coded boxes highlight places a user can click on the page to navigate to the locations defined in the legend.

Exhibit 8 TLG Hospital Safety Grade Page Navigation Structure



Source: "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>, PBHN000003151.

Note: This chart displays the possible routes a user could take from a Hospital Safety Grade Page. Routes are terminated at the point at which they either (1) lead to a page outside of the Hospital Safety Grade Page or (2) contain no more clickable links on the page. The route to reach the methodology document exceeds this criteria but is included to show the location of the "Limited Achievement" language. I have excluded routes navigable via the fixed dropdown menus in the navigation bar and the fixed hyperlinks in the sub-footer. I understand that it is possible to reach the methodology document via those routes.

65. TLG purports to disclose its imputation methodology on TLG's websites.¹²⁵ One such purported disclosure appears in the "Notes and Definitions" section underneath the "tabs" on the Hospital Safety Grade Page.¹²⁶ When a consumer navigates to one of the four imputed measures on a TLG Hospital Safety Grade Page, TLG presents the imputed numeric score on that measure and an asterisk, which points to a footnote ("footnote disclosure"), as outlined in the flowchart in Exhibit 8. Exhibits 9, 10, 11, and 12 below show four images of a TLG Hospital Safety Grade Page, navigated to each of the four imputed measures. The footnote disclosure appears in small font near the bottom of each page and states, "* The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available."¹²⁷ Thus, while the footnote disclosure states that "a score" was assigned by TLG, it does not convey that this assigned score was the minimum score for the imputed measure.

¹²⁵ Motion to Dismiss, p. 8.

¹²⁶ Motion to Dismiss, pp. 8–9.

¹²⁷ See, e.g., Motion to Dismiss, Exhibit 29, p. 3 (citing "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>), PBHN000003009–11.

Exhibit 9 The Footnote Disclosure on TLG’s Hospital Safety Grade Page for Palm Beach Gardens Medical Center, When Navigated to the Imputed Measure: *Doctors order medications through a computer*

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This Hospital's Grade

F

Palm Beach Gardens Medical Center

3360 Burns Road
Palm Beach Gardens, FL 33410-4304
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[View this hospital's Leapfrog Hospital Survey Results](#)

[Show Recent Past Grades](#)

[Detailed table view](#)

Order 2½ years of detailed scoring for this hospital for \$2.95

Learn how to use the Leapfrog Hospital Safety Grade

Infections | **Problems with Surgery** | **Safety Problems** | **Practices to Prevent Errors** | **Doctors, Nurses & Hospital Staff**

Doctors order medications through a computer

Hospital Performs:
Worse Than Average | Better Than Average

This Hospital's Score:
15 *

Best Hospital's Score:
100

Average Hospital's Score:
80.23

Worst Hospital's Score:
15

Doctors order medications through a computer
Hospitals can use Computerized Physician Order Entry (CPOE) systems to order medications for patients in the hospital. Instead of writing out prescriptions by hand, good CPOE systems alert the doctor if they try to order a medication that could cause harm, such as prescribing an adult dosage for a child. CPOE systems help to reduce medication errors in the hospital.

What safer hospitals do:
Hospitals use CPOE systems in all areas of the hospital and regularly test these systems to ensure they are alerting doctors to potential ordering errors.

Notes and Definitions

1. **Declined to Report:** The hospital was asked to provide this information to the public, but did not.

2. **Not Available:** "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.

3. **Straight A:** The hospital has earned an A Grade for five consecutive grading rounds or more, qualifying it for recognition as a "Straight A" hospital.

4. * The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.

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Source: “Palm Beach Gardens Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the “Practices to Prevent Errors” tab and “Doctors order medications through a computer” measure. Parts of the page marked by the red boxes show the imputed measure “Doctors order medications through a computer” and TLG’s footnote disclosure. The footnote disclosure states “* The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.”

Exhibit 10 The Footnote Disclosure on TLG's Hospital Safety Grade Page for Palm Beach Gardens Medical Center, When Navigated to the Imputed Measure: *Safe medication administration*

The screenshot displays the Leapfrog Hospital Safety Grade website for Palm Beach Gardens Medical Center. The page is titled "Palm Beach Gardens Medical Center" and shows the hospital's address: 3360 Burns Road, Palm Beach Gardens, FL 33410-4304. The page is for the Spring 2025 grade.

The "Safe medication administration" measure is highlighted with a red box. It shows a score of 25, which is significantly lower than the best hospital score of 100 and the average hospital score of 81.87. The measure is described as "Safe medication administration" and includes a brief explanation of the measure.

Below the measure, there is a footnote disclosure: "4. * The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available." This disclosure is also highlighted with a red box.

The page also includes a "Notes and Definitions" section with four footnotes:

1. Declined to Report: The hospital was asked to provide this information to the public, but did not.
2. Not Available: "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.
3. Straight A: The hospital has earned an A Grade for five consecutive grading rounds or more, qualifying it for recognition as a "Straight A" hospital.
4. * The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.

The page also includes a "LEGAL DISCLAIMER" section at the bottom, which states: "THE LEAPFROG GROUP. The Leapfrog Hospital Safety Grade scores hospitals on their overall performance in keeping patients safe from preventable harm and medical errors. The grades are derived from expert analysis of publicly available data using up to 31 evidence-based, national measures of hospital safety. No specific representation is made; nor shall The Leapfrog Group be liable with respect to any individual patient's potential or actual outcome as a result of receiving services performed at any of these hospitals. Leapfrog Hospital Safety Grades cannot be reproduced without expressed written permission from The Leapfrog Group."

Source: "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the "Practices to Prevent Errors" tab and "Safe medication administration" measure. Parts of the page marked by the red boxes show the imputed measure "Safe medication administration" and TLG's footnote disclosure. The footnote disclosure states "4. * The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available."

Exhibit 11 The Footnote Disclosure on TLG's Hospital Safety Grade Page for Palm Beach Gardens Medical Center, When Navigated to the Imputed Measure: *Handwashing*

The screenshot displays the Leapfrog Hospital Safety Grade website. At the top, there's a navigation bar with links like 'Join Our Mailing List', 'Newsroom', and 'Donate Now'. Below this, the page title is 'Palm Beach Gardens Medical Center' with its address and a link to 'View this hospital's Leapfrog Hospital Survey Results'. A large 'F' grade is shown for 'SPRING 2025'. A red box highlights the 'Handwashing' measure under the 'Safety Problems' category. Below the measure, a red box highlights the footnote disclosure: '4. * The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.' The page also includes a 'Notes and Definitions' section with footnotes explaining 'Declined to Report' and 'Not Available'. At the bottom, there's a footer with 'THE LEAPFROG GROUP' logo, contact information, and a disclaimer.

Leapfrog HOSPITAL SAFETY GRADE

Palm Beach Gardens Medical Center
3360 Burns Road
Palm Beach Gardens, FL 33410-4304
Map and Directions

SPRING 2025

Handwashing

Hospital Performs:
Worse Than Average Better Than Average

This Hospital's Score:
15 *

Best Hospital's Score:
100

Average Hospital's Score:
74.40

Worst Hospital's Score:
15

Notes and Definitions

1. **Declined to Report:** The hospital was asked to provide this information to the public, but did not.

2. **Not Available:** "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.

3. **Single A:** The hospital has earned an A Grade for five consecutive grading periods or more, qualifying it for recognition as a "Single A" hospital.

4. * **The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.**

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Source: "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the "Practices to Prevent Errors" tab and "Handwashing" measure. Parts of the page marked by the red boxes show the imputed measure "Handwashing" and TLG's footnote disclosure. The footnote disclosure states "* The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available."

Exhibit 12 The Footnote Disclosure on TLG’s Hospital Safety Grade Page for Palm Beach Gardens Medical Center, When Navigated to the Imputed Measure: *Specially trained doctors care for ICU patients*

The screenshot displays the Leapfrog Hospital Safety Grade website. At the top, there is a navigation bar with links for 'Join Our Mailing List', 'Newsroom', and 'Donate Now'. Below this, the main header includes the Leapfrog Hospital Safety Grade logo and a 'Back to Results' button. The page title is 'Palm Beach Gardens Medical Center', with its address (3360 Burns Road, Palm Beach Gardens, FL 33410-4304) and a 'View this hospital's Leapfrog Hospital Survey Results' link. A 'Show Recent Past Grades' link is also present. A 'Detailed table view' link is available, along with a note that 'Order 2+ years of detailed scores for this hospital for \$2.95'. Below the header, there is a section titled 'Learn how to use the Leapfrog Hospital Safety Grade' with an illustration of a person using a laptop. The main content area is divided into several tabs: 'Infections', 'Problems with Surgery', 'Safety Problems', 'Practices to Prevent Errors', and 'Doctors, Nurses & Hospital Staff'. The 'Safety Problems' tab is selected, showing a 'Specially trained doctors care for ICU patients' measure. This measure is represented by a red circle with a question mark and a 'Declined to Report' status. Below this, the 'Hospital Performs' section shows a score of 5, with a 'This Hospital's Score' of 5 and a 'Best Hospital's Score' of 100. The 'Average Hospital's Score' is 65.15, and the 'Worst Hospital's Score' is 5. A footnote disclosure is provided: '1. Declined to Report: The hospital was asked to provide this information to the public, but did not.' The footnote is marked with a red box. Below the footnote, there is a 'Back to top' link. The footer of the page includes the Leapfrog Hospital Safety Grade logo, a 'Join Us' section with social media links, and a 'Donate Now' button. The footer also contains a 'What is Patient Safety?' section with links for 'Errors, Injuries, Accidents, Infections', 'Why the Hospital Safety Grade Works', 'For Hospitals', 'About Our Movement', 'Licenses & Permissions', and 'Data License'. The footer also includes a 'Medical Treatment' section with a disclaimer and a 'Privacy Policy' link.

Source: “Palm Beach Gardens Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the “Doctors, Nurses & Hospital Staff” tab and “Specially trained doctors care for ICU patients” measure. Parts of the page marked by the red boxes show the imputed measure “Specially trained doctors care for ICU patients” and TLG’s footnote disclosure. The footnote disclosure states “* The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.”

66. TLG introduced the footnote disclosure in response to feedback on its Fall 2024 methodology update. Specifically, TLG received feedback that its minimum score assignment misrepresented a hospital's performance to consumers and even acknowledged, itself, that consumers may "misinterpret" the scores on the imputed measures.¹²⁸ As a result, TLG decided to add a footnote disclosure.¹²⁹ While developing the language for the footnote disclosure, a TLG employee noted that TLG was "arbitrarily assigning [non-participating hospitals] points associated with the bottom scoring category."¹³⁰ Nonetheless, the footnote disclosure omits language about TLG's practice of assigning the minimum score on the imputed measures.

67. The footnote disclosure *only* appears on a TLG Hospital Safety Grade Page when a consumer has navigated to one of the four imputed measures on the measure's respective tab, as shown in Exhibit 8. Thus, upon first navigating to the TLG Hospital Safety Grade Pages for Plaintiff Hospitals, a consumer is exposed to TLG's overall "D" or "F" letter grade for the hospital without the footnote disclosure, because the default view of the "Infections" tab and "MRSA Infections" measure does not contain the footnote disclosure, as shown in Exhibit 6 above.

68. Similarly, when a consumer is viewing any of the non-imputed measures within the tabs that contain the four imputed measures (i.e., the tabs "Doctors, Nurses & Hospital Staff" and "Practices to Prevent Errors"), the footnote disclosure is not displayed. For example, Exhibit 13 shows the Hospital Safety Grade Page for Plaintiff Hospital Palm Beach Gardens Medical Center, navigated to the tab "Doctors, Nurses & Hospital Staff," and the measure "Effective leadership to prevent errors." The tab "Doctors, Nurses & Hospital Staff" also contains one of the four imputed measures, "Specially trained doctors care for ICU patients." In this view, a consumer would be exposed to both the "F" overall letter grade for the hospital as well as dial graphic for the imputed measure indicating that the hospital performed "[w]orse [t]han [a]verage" (i.e., red shaded region of the dial). However, the footnote disclosure does not appear. This would also be the case for consumers who navigated to the "Practices to Prevent Errors" tab (which contains the imputed measures "Doctors order medications through a computer," "Safe medication administration," and "Handwashing") and to the other, non-imputed measures in this tab.

¹²⁸ LEAPFROG00178628–633 at 629.

¹²⁹ LEAPFROG00178628–633 at 629.

¹³⁰ LEAPFROG00427863–633 at 863.

Exhibit 13 Example of TLG's Hospital Safety Grade Page, Navigated to a Non-Imputed Measure, where the Footnote Disclosure Does Not Appear

The screenshot displays the Leapfrog Hospital Safety Grade website for Palm Beach Gardens Medical Center. The page is titled "Palm Beach Gardens Medical Center" and shows the hospital's address: 3360 Burns Road, Palm Beach Gardens, FL 33410-4304. The page is navigated to the "Doctors, Nurses & Hospital Staff" tab, which shows a score of 120.00 for the "Effective leadership to prevent errors" measure. The page also includes a "Back to Results" button and a "Show Recent Past Grades" link. The "Effective leadership to prevent errors" measure is highlighted with a yellow box, and the "Specially trained doctors care for ICU patients" measure is highlighted with a red box. The page also includes a "Notes and Definitions" section and a "Back to top" link.

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This Hospital's Grade

F

Palm Beach Gardens Medical Center

3360 Burns Road
Palm Beach Gardens, FL 33410-4304
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[View this hospital's Leapfrog Hospital Survey Results](#)

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Learn how to use the Leapfrog Hospital Safety Grade

Infections | **Problems with Surgery** | **Safety Problems** | **Practices to Prevent Errors** | **Doctors, Nurses & Hospital Staff**

Declined to Report?
Effective leadership to prevent errors

Declined to Report?
Nursing and Bedside Care for Patients

Specially trained doctors care for ICU patients

Communication with Doctors

Communication with Nurses

Responsiveness of Hospital Staff

Hospital Performs:
Worse Than Average | Better Than Average

This Hospital's Score:
Declined to Report

Best Hospital's Score:
120.00

Average Hospital's Score:
117.49

Worst Hospital's Score:
9.23

Notes and Definitions

1. **Declined to Report:** The hospital was asked to provide this information to the public, but did not.

2. **Not Available:** "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.

3. **Straight A:** The hospital has earned an A Grade for five consecutive grading rounds or more, qualifying it for recognition as a "Straight A" hospital.

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Source: "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the "Doctors, Nurses & Hospital Staff" tab and "Effective leadership to prevent errors" measure, as marked by the yellow box. Parts of the page marked by the red boxes show the imputed measure "Specially trained doctors care for ICU patients" and the location where TLG's footnote disclosure appears for the imputed measures (e.g., Exhibit 9).

69. Moreover, within the tabs that contain the imputed measures, TLG presents dial graphics for other, non-imputed measures that state the hospital “Declined to Report” on these non-imputed measures. For example, on TLG’s Hospital Safety Grade Page for Palm Beach Gardens Medical Center, the “Declined to Report” dial graphic appears in the tab “Practices to Prevent Errors” for the non-imputed measure “Staff work together to prevent errors,” as shown in Exhibit 9 and in the tab “Doctors, Nurses & Hospital Staff,” for the non-imputed measures “Effective leadership to prevent errors” and “Nursing and Bedside Care for Patients,” as shown in Exhibit 12. Notably, the non-imputed measures share a key similarity with the imputed measures: they are all measures whose scores are based on TLG’s voluntary hospital survey and, thus, for which TLG has no data for non-participating hospitals.¹³¹

70. Because of this presentation, many consumers would likely conclude that the dial graphics showing a low score for the imputed measures are based on more or stronger evidence than the “Declined to Respond” dial graphics for the non-imputed measures. Indeed, research has found that consumers make inferences about a product characteristic using not only the information provided about the characteristic but also using information that is omitted about that characteristic. For example, a study in the context of food product labels exposed consumers to product labels for three peanut oil products, and the study varied whether none, one, two, or all of the product labels contained the phrase “cholesterol free.” Consumers who saw only one or two of product labels with the “cholesterol free” phrase were more likely to believe that the *other* products, which did not display this label, contained cholesterol, compared to consumers who saw no product labels with the “cholesterol free” phrase.¹³² This is an example of inductive reasoning, where people draw general conclusions from specific examples.¹³³

¹³¹ Motion to Dismiss, Exhibit 5, p. 6–7 (citing Methodology Document), PBHN000003012–40. TLG refers to these measures by different names in its methodology document: “Safe Practice 1: Culture of Leadership Structures and Systems” for “Effective leadership to prevent errors”; “Safe Practice 2: Culture Measurement, Feedback & Intervention” for “Staff work together to prevent errors”; “Total Nursing Care Hours per Patient Day” for “Nursing and bedside care for patients”; “Hand Hygiene” for “Handwashing.” See “Public Reporting Website Measure Crosswalk,” *The Leapfrog Group*, Spring 2025, https://www.hospitalsafetygrade.org/media/file/PublicReportingWebsiteMeasureCrosswalk_Spring2025.pdf, PBHN000004116–8.

¹³² Burke, S. J., et al. (1997), “Displaying Common but Previously Neglected Health Claims on Product Labels: Understanding Competitive Advantages, Deception, and Education,” *Journal of Public Policy & Marketing*, 16, 2, 242–255 at pp. 248–249, PBHN000003353–67.

¹³³ Kardes, F. R., et al. (2004), “Consumer Inference: A Review of Processes, Bases, and Judgment Contexts,” *Journal of Consumer Psychology*, 14, 3, 230–256 at p. 230, PBHN000003849–76.

71. According to its Motion to Dismiss, TLG also purports to display imputation disclosures in 15 other locations (i.e., pages or documents) on the [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org) and [leapfroggroup.org](https://www.leapfroggroup.org) websites, in addition to the footnote disclosure.¹³⁴ However, many of the examples TLG cites do not state that TLG assigns the minimum score on the imputed measures to hospitals that do not respond to its survey. For example:

- On the page “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” TLG states that “[i]f a hospital does not report to the Leapfrog Hospital Survey, other sources of data are used to calculate a Grade.”¹³⁵
- On the page “About the Grade,” TLG states that “[i]n some cases where a hospital’s information is not available for a certain measure, Leapfrog uses a supplemental data source. In cases where a hospital’s information is not available from any data source, Leapfrog has outlined a methodology for dealing with the missing data.”¹³⁶

72. In fact, analysis of not only the locations TLG explicitly cites as examples of disclosures, but also all locations cited as exhibits to either TLG’s Motion to Dismiss or Plaintiffs’ Motion for Preliminary Injunction, finds that only a small subset of such locations state TLG assigns the minimum score (i.e., a score based on “Limited Achievement”) on the imputed measures.¹³⁷ Specifically, of the 38 locations analyzed, only nine mention imputing data for non-participating hospitals at all, and only four say that hospitals will be given a score equivalent to “Limited Achievement” for imputed measures:¹³⁸ (1) TLG’s “Fall 2024 Methodology Updates” document, which first announced the Fall 2024 methodology change,¹³⁹ (2) the “2025 Leapfrog Hospital Survey,”¹⁴⁰ which is the survey form that hospitals fill out to provide data to TLG and is not directed

¹³⁴ Motion to Dismiss, pp. 8–9.

¹³⁵ Motion to Dismiss, Exhibit 3, p. 4 (citing “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

¹³⁶ Motion to Dismiss, Exhibit 4, p. 4 (citing “About the Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/about-the-grade>), PBHN000002619–25.

¹³⁷ Motion to Dismiss; Motion for Preliminary Injunction. For both the Motion to Dismiss and the Motion for Preliminary Injunction, I restricted my analysis to the set of exhibits that consist of pages from [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org) or [leapfroggroup.org](https://www.leapfroggroup.org). I exclude from my analysis Motion for Preliminary Injunction, Exhibit 50, “June 22, 2012 Letter from the American Hospital Association’s then-President,” because although it is, or was at one point, available on [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org), it consists of a letter to The Leapfrog Group rather than information published by The Leapfrog Group. See Workpaper 1.

¹³⁸ This analysis is at the location-level. Locations (i.e., pages or documents) on TLG’s website may contain many sentences or paragraphs of text. See Workpaper 1.

¹³⁹ Motion to Dismiss, Exhibit 38, p. 3 (citing “Final Updates to the Leapfrog Hospital Safety Grade Methodology for Fall 2024,” *The Leapfrog Group*, https://www.hospitalsafetygrade.org/media/file/Fall2024HospitalSafetyGrade_FinalMethodologyChanges.pdf), PBHN000002632–7 (“For hospitals that do not have historical data from the last two rounds of the Safety Grade ... hospitals will be assigned a point value that is equivalent to receiving ‘Limited Achievement’.”).

¹⁴⁰ Motion to Dismiss, Exhibit 21, p. 83 (citing “2025 Leapfrog Hospital Survey,” *The Leapfrog Group*, https://www.leapfroggroup.org/sites/default/files/Files/2025%20HospitalSurvey_20250502_v9.1%20%28version%20%29.pdf),

towards consumers of TLG's Hospital Safety Grades, (3) TLG's Fall 2024 "Scoring Methodology" document,¹⁴¹ and (4) TLG's Spring 2025 "Scoring Methodology" document ("methodology document"),¹⁴² which I understand is a newer version of TLG's Fall 2024 "Scoring Methodology" document.

73. Of these four documents, I understand that only one—the methodology document—can be accessed through TLG's Hospital Safety Grade Pages today.¹⁴³ I am not aware of any way that a user can navigate to the remaining three documents from a TLG Hospital Safety Grade Page today.

74. The only disclosure that can be accessed from TLG's Hospital Safety Grade Pages is a statement in found in TLG's 28-page methodology document.¹⁴⁴ On page 16 of this methodology document, TLG states, among other statements, that "If the hospital does not have historical data from the last two rounds (i.e., fall 2024, spring 2024) of the Safety Grade, the hospital is assigned a point value that is equivalent to receiving 'Limited Achievement' for this measure on the Leapfrog Hospital Survey."¹⁴⁵ This information is not displayed on TLG's Hospital Safety Grade Page. While it is possible to navigate to the methodology document from TLG's Hospital Safety Grade pages for Plaintiff Hospitals, navigating to the document and then navigating to the relevant information within the document both require multiple steps, such that it is unlikely that many consumers would view this information, as I discuss in Section VIII.D.

75. In addition, consumers may also be exposed to other statements about missing data on TLG's websites that are either irrelevant to the imputed measures or do not discuss TLG's imputation methodology. Thus, consumers seeking to understand the imputed measures' scores would need to evaluate these statements and understand to disregard them in their assessment of the imputed measures. In fact, of the 38 locations I analyzed, nearly half (16) mention missing data (in any context) and eight mention missing data related to any measure underlying the

PBHN000002651–3003 ("Hospitals that submit the Survey, but do not submit an Adult Inpatient Test via the CPOE Evaluation Tool, are scored and publicly reported as 'Limited Achievement' on the CPOE measure.").

¹⁴¹ Motion to Dismiss, Exhibit 31, p. 16 (citing Fall 2024 "Scoring Methodology"), PBHN000003044–69 ("Hospitals which do not have historical data from the two most recent rounds of the Safety Grade are assigned a point value that is equivalent to receiving 'Limited Achievement' for [the CPOE, BCMA, IPS, and Hand Hygiene] measure on the Leapfrog Hospital Survey.").

¹⁴² Motion to Dismiss, Exhibit 5, p. 18 (citing Methodology Document), PBHN000003012–40 ("Hospitals which do not have historical data from the two most recent rounds of the Safety Grade are "assigned a point value that is equivalent to receiving 'Limited Achievement' for [the CPOE, BCMA, IPS, and Hand Hygiene] measure on the Leapfrog Hospital Survey.").

¹⁴³ My understanding of which pages can be accessed from a TLG Hospital Safety Grade Page is based on a review of the website as of July 30, 2025.

¹⁴⁴ See Workpaper 1.

¹⁴⁵ Motion to Dismiss, Exhibit 5, p. 18 (citing Methodology Document, p. 16), PBHN000003012–40.

Hospital Safety Grade, all *without* reference to an imputation methodology or the minimum score assignment.¹⁴⁶ Thus, consumers would not only need to navigate to one of only four locations on TLG's website to be presented with information about its practice of assigning minimum scores to non-participating hospitals on the imputed measures, but consumers would also need to evaluate and understand to disregard additional, irrelevant information that TLG presents.

76. In sum, while TLG purports to disclose its imputation methodology on its Hospital Safety Grade Pages for Plaintiff Hospitals, the footnote disclosure does not state that the imputation methodology involves assigning the minimum score on the imputed measures. Moreover, while TLG purports to have many imputation disclosures on its website, the only one that is accessible from a TLG Hospital Safety Grade Page and in which TLG discloses that the imputation methodology involves assigning the minimum score on the imputed measures (which TLG refers to as "Limited Achievement") is found on page 16 of its 28-page methodology document. Finally, consumers seeking to understand the imputed measures' scores would also need to understand to disregard TLG's numerous other statements about missing data that are irrelevant to its imputation methodology or its practice of assigning the minimum score on the imputed measures.

B. TLG Does Not Directly Disclose that its Minimum Score Assignment Lowers Non-Participating Hospitals' Hospital Safety Grades

77. Plaintiffs also allege that TLG fails to adequately disclose that its practice of assigning the minimum score to non-participating hospitals on the imputed measures "result[s] in artificially deflated overall grades."¹⁴⁷ Indeed, consistent with Plaintiffs' allegations, staff at another hospital group, Allina Health, raised concerns that "[t]he public will not understand nor dig into the methodology of these grades, and hospitals will be falsely represented with a lower grade, because they chose not to complete a survey."¹⁴⁸ I understand that Professor Nicholson finds that, due to TLG's imputation methodology, Plaintiff Hospitals' Safety Grades were one to two letter grades lower than the grades they would have received had they participated in TLG's survey and responded as the average participating hospitals does.¹⁴⁹

¹⁴⁶ Workpaper 1.

¹⁴⁷ Complaint, ¶ 52.

¹⁴⁸ LEAPFROG00439030; LEAPFROG00178624–627 at 625.

¹⁴⁹ Expert Report of Professor Sean Nicholson, August 7, 2025, Section X.B.

78. I also analyzed content on TLG’s websites to assess whether and to what extent they contained information on the impact of TLG’s imputation methodology on TLG’s Hospital Safety Grades for non-participating hospitals. Specifically, I analyzed the same 38 locations on TLG’s websites as in Section VIII.A, which include not only the locations TLG explicitly cites as examples of disclosures but also all locations cited as exhibits to TLG’s Motion to Dismiss and Plaintiffs’ Motion for Preliminary Injunction. Of the 38 locations, only 23 even present a relationship between Hospital Safety Grades and underlying measures. Of these 23 locations, only four explicitly discuss TLG’s minimum score assignment and only one of those four is accessible from the Hospital Safety Grade Pages, as I explained in VIII.A. For example, TLG presents the following language without any reference to the fact that some measures are imputed on its “Frequently Asked Questions About The Leapfrog Hospital Safety Grade” page:

- “The grade uses over 30 measures including rates of preventable errors, injuries and infections, and whether hospitals have systems in place to prevent them.”¹⁵⁰
- “Leapfrog experts and advisors at the Johns Hopkins Armstrong Institute for Patient Safety and Quality regularly review all publicly available measures of safety and the methodology to determine a hospital’s letter grade.”¹⁵¹

79. Moreover, of the 23 locations that present a relationship between the Hospital Safety Grades and underlying measures, a majority indicate to consumers that TLG’s Hospital Safety Grades have a basis in actual measurement of hospitals’ performance. Specifically, 16 of these locations include statements that a hospital’s Safety Grade is either based on data (e.g., from the Center for Medicare and Medicaid Services) or based on the hospital’s performance on safety. For example, TLG’s “About the Grade” page includes the statements:

- “***A hospital must have enough safety data available for our experts to issue them a letter grade.*** Hospitals missing more than six process measures, more than five outcome measures, or PS190 are not graded.”¹⁵²

¹⁵⁰ Motion to Dismiss, Exhibit 3, p. 2 (citing “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

¹⁵¹ Motion to Dismiss, Exhibit 3, p. 6 (citing “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

¹⁵² Emphasis added. Motion to Dismiss, Exhibit 4, p. 6 (citing “About the Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/about-the-grade>), PBHN000002619–25.

- “Taken together, those performance measures produce a single letter grade representing a hospital’s overall performance in keeping patients safe from preventable harm and medical errors.”¹⁵³

80. In fact, in some locations, TLG even explicitly downplays the impact of non-participation in its survey on a hospital’s letter grade. For example, TLG’s “Frequently Asked Questions About The Leapfrog Hospital Safety Grade” page states that “The Leapfrog Hospital Safety Grade is a letter grade Leapfrog biannually assigns to general hospitals in the United States, whether they voluntarily report data to Leapfrog or not. *If a hospital does not report to the Leapfrog Hospital Survey, other sources of data are used to calculate a Grade.*”¹⁵⁴ The majority of data used to calculate the Safety Grade comes from the Centers for Medicare and Medicaid Services (CMS).¹⁵⁴ The same page also tells consumers that a “Hospital Safety Grade reflects how well a hospital does on safety, *not whether they complete the Leapfrog Hospital Survey.*”¹⁵⁵ TLG’s websites include limited, and often even conflicting, information about its imputation methodology and the effect of non-participation on Hospital Safety Grades. It is unlikely that many consumers would understand that non-participation would lead to a minimum score assigned on the imputed measures and, in turn, a lower Hospital Safety Grade.

C. It Is Unlikely that Many Consumers Read TLG’s Footnote Disclosure Located at the Bottom of the Hospital Safety Grade Page

81. Even if the footnote disclosure stated that the imputation methodology involves assigning the minimum score to Plaintiff Hospitals, which it does not, many consumers are unlikely to read the footnote disclosure in this context. Specifically, the footnote disclosure is placed “below the fold” on TLG’s Hospital Safety Grade Pages for Plaintiff Hospitals, which requires consumers to scroll down to view the information, and research has found that, in a variety of contexts, consumers are unlikely to view information “below the fold.”¹⁵⁶ Such behavior may be particularly

¹⁵³ Motion to Dismiss, Exhibit 4, p. 2 (citing “About the Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/about-the-grade>), PBHN000002619–25.

¹⁵⁴ Emphasis added. Motion to Dismiss, Exhibit 3, p. 4 (citing “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

¹⁵⁵ Emphasis added. Motion to Dismiss, Exhibit 3, p. 4 (citing “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

¹⁵⁶ While the location of the footnote disclosure for an individual consumer may depend on how that consumer accesses TLG’s Hospital Safety Grade Pages (i.e., from a mobile device or computer), I observe that the footnote disclosure is below the fold in both the mobile and desktop views of the website. See, e.g., “Good Samaritan Medical Center,” *The Leapfrog Group*,

relevant in the context of TLG Hospital Safety Grade Pages that present low or failing grades, which are likely to elicit negative, emotional reactions from consumers. In this context, consumers are unlikely to search for more information, as explained in Section VI.C.

82. Studies, including my own research, have found that, in a variety of settings, information that is not visible without scrolling further down the page (i.e., information below the fold) can be less likely to be viewed.¹⁵⁷ Moreover, research has found that information further down the page can be less likely to be viewed compared to information conveyed earlier on the page.¹⁵⁸ For example, according to one study, “there was a dramatic drop-off in user attention at the position of the page fold” and that information just below the fold was less than half as likely to be viewed as information just above the fold.¹⁵⁹ Another study found that users spent less than 20% of their attention on information below the fold.¹⁶⁰ As an example, lower ranked results on search engine results pages receive dramatically less user engagement.¹⁶¹ Taken together, it is likely that many consumers would not have reviewed the footnote disclosure on TLG’s Hospital Safety Grade Pages.

<https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center>. See also “For Display Ads, Being Seen Matters More than Being Clicked,” *ComScore*, April 24, 2012, <https://www.comscore.com/Insights/Press-Releases/2012/4/For-Display-Ads-Being-Seen-Matters-More-than-Being-Clicked>, PBHN000003671–3.

¹⁵⁷ “Scrolling and Attention (Original Research Study),” *Nielsen Norman Group*, March 21, 2010, <https://www.nngroup.com/articles/scrolling-and-attention-original-research/>, PBHN000004161–4; “The Fold Manifesto: Why the Page Fold Still Matters,” *Nielsen Norman Group*, February 1, 2015, <https://www.nngroup.com/articles/page-fold-manifesto/>, PBHN000004225–8; Ghose, A. and S. Yang (2009), “An Empirical Analysis of Search Engine Advertising: Sponsored Search in Electronic Markets,” *Management Science*, 55, 10, 1605–1622 at p. 1614, PBHN000003686–712; Ghose, A., et al. (2014), “Examining the Impact of Ranking on Consumer Behavior and Search Engine Revenue,” *Management Science*, 60, 7, 1–23 at pp. 16–17, PBHN000003713–35; Shi, S. W. and M. Trusov (2020), “The Path to Click: Are You on It?” *Marketing Science*, 40, 2, 344–365 at pp. 360, 363, PBHN000004165–87; Berger, J. and K. L. Milkman (2011), “What Makes Online Content Viral?” *Journal of Marketing Research*, 49, 2, 192–205, Table 4, PBHN000003264–80; Berger, J., et al. (2023), “What Holds Attention? Linguistic Drivers of Engagement,” *Journal of Marketing*, 87, 5, 793–809, Web Appendix, Figure W1, PBHN000003317–33.

¹⁵⁸ “The Importance of Being Seen: Viewability Insights for Digital Marketers and Publishers,” *Google*, November 2014, https://think.storage.googleapis.com/docs/the-importance-of-being-seen_study.pdf, pp. 9–13, PBHN000004229–54.

¹⁵⁹ “The Fold Manifesto: Why the Page Fold Still Matters,” *Nielsen Norman Group*, February 1, 2015, <https://www.nngroup.com/articles/page-fold-manifesto/>, PBHN000004225–8.

¹⁶⁰ “Scrolling and Attention (Original Research Study),” *Nielsen Norman Group*, March 21, 2010, <https://www.nngroup.com/articles/scrolling-and-attention-original-research/>, PBHN000004161–4.

¹⁶¹ Ghose, A. and S. Yang (2009), “An Empirical Analysis of Search Engine Advertising: Sponsored Search in Electronic Markets,” *Management Science*, 55, 10, 1605–1622 at p. 1614, PBHN000003686–712; Ghose, A., et al. (2014), “Examining the Impact of Ranking on Consumer Behavior and Search Engine Revenue,” *Management Science*, 60, 7, 1–23 at pp. 16–17, PBHN000003713–35.

D. It Is Unlikely that Many Consumers Read TLG's Disclosure in the Methodology Document

83. As explained in Section VIII.A, the methodology document is the only TLG imputation disclosure accessible from the Hospital Safety Grade page that states that the imputation methodology involves assigning the minimum score to non-participating hospitals. At least some consumers on TLG's Hospital Safety Grade Page for a Plaintiff Hospital would be unlikely to even open the methodology document, because reaching it from a Hospital Safety Grade Page requires multiple steps, as shown in Exhibits 14 and 15. Moreover, accessing the specific language which explains that TLG assigns the minimum score to non-participating hospitals requires even more steps, as shown in Exhibits 16 to 19. For example, one possible path a consumer could take is as follows:¹⁶²

- First, a consumer must click either the "Detailed table view" link on the top right of the page or the "For details on sources, click here" link below the descriptions of individual measures, which brings the consumer to a table with the hospital's scores on all measures (Exhibit 14). As explained in Section VIII.A, these actions are two of many, including navigating to different tabs, measures, and multiple different links, that a consumer can choose to undertake from a Hospital Safety Grade Page.
- Second, on the "Detailed table view" page, a consumer must scroll to the very bottom of this page, below the table, and click the link that reads, "For a full description of the methodology, click here" (Exhibit 15).
- Third, for those who click on this link, they would then access the 28-page methodology document (Exhibit 16).
- Fourth, consumers who scroll beyond the cover page of this document would then be presented with a Table of Contents, which includes the entry "Imputation Method for CPOE, BCMA, IPS, and Hand Hygiene" (Exhibit 17).¹⁶³ In this table of contents and the rest of the document, the names of the imputed measures are different than the names that appear on TLG's Hospital Safety Grade Pages (e.g., "Bar Code Medication Administration (BCMA)" in the methodology document is "Safe medication administration" on the Hospital Safety Grade Page) or even abbreviated (e.g., "BCMA").

¹⁶² Research has found that consumers are less likely to view information that is below the fold on a screen or requires scrolling, as explained in Section VIII.C. I understand that the methodology document is also reachable from a Hospital Safety Grade Page via routes navigable from the fixed dropdown menus in the navigation bar and the fixed hyperlinks in the sub-footer. I understand that reaching the methodology document via these routes requires the same number of clicks as the route described in the text.

¹⁶³ I understand that consumers can take multiple routes to reach the "Limited Achievement" language on the 16th page of this document. For example, some consumers may take more steps, such as navigating first to each measure under the "Process/Structural Measures" section of the Table of Contents, navigating to "Using Secondary Data Sources," and then scrolling to the 16th page of the document.

- Fifth, consumers who click on “Imputation Method for CPOE, BCMA, IPS, and Hand Hygiene” are then taken to page 15 of the methodology document, which describes the imputation methodology for non-participating hospitals that had a score assigned in the previous two rounds of grades (Exhibit 18).
- Finally, consumers must scroll down to page 16 of the methodology document, which describes, among other things, TLG’s imputation methodology for non-participating hospitals that did not have a score assigned in the previous two rounds of grades (Exhibit 19).

84. Research has found that consumers are less likely to navigate to pages that require more clicks to access in certain contexts. For example, a study of Wikipedia users’ search for information found that, for each click needed to navigate to information, “there is roughly a 10% chance of the user dropping out” from the navigation process.¹⁶⁴ Given the numerous steps involved, it is unlikely that a consumer would navigate to the methodology document in general, or the disclosure in this document about TLG’s practice of assigning the minimum score to non-participating hospitals on the imputed measures.

¹⁶⁴ Scaria, A. T., et al. (2014), “The Last Click: Why Users Give Up Information Network Navigation,” in Proceedings of the 7th ACM International Conference on Web Search and Data Mining, 213–222 at 215, PBHN000004151–60.

Exhibit 14 Steps to Navigate to TLG's Disclosure in the Methodology Document from a Hospital Safety Grade Page, Step 1

Step 1:
Consumer has to click either on "Detailed table view" or on "For details on sources, click here."

The screenshot displays the Leapfrog Hospital Safety Grade website for Good Samaritan Medical Center. The page features a navigation bar with links such as "What is Patient Safety?", "Your Hospital's Safety Grade", "What You Can Do to Stay Safe", "For Hospitals", "Licenses & Permissions", and "About Our Movement". The main content area shows the hospital's grade (D) for Spring 2025, along with its address and a link to "View this hospital's Leapfrog Hospital Survey Results". A "Detailed table view" link is highlighted in a red box. Below this, there are tabs for "Infections", "Problems with Surgery", "Safety Problems", "Practices to Prevent Errors", and "Doctors, Nurses & Hospital Staff". The "Infections" tab is selected, showing a gauge for MRSA infection with a score of 0.000. A "For details on source, click here." link is highlighted in a red box. The footer contains a "Legal Disclaimer" and a "Back to top" link.

Source: "Good Samaritan Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Good Samaritan Medical Center, navigated to the "Infections" tab and "MRSA Infection" measure, which is the default page view. Parts of the page marked by the red boxes show the "Detailed table view" link and the "For details on source, click here." link.

Exhibit 15 Steps to Navigate to TLG’s Disclosure in the Methodology Document from a Hospital Safety Grade Page, Step 2

Step 2:
Consumer has to scroll to the bottom of the “Detailed table view” page and click on “For a full description of the methodology, click here.”

The screenshot displays the Leapfrog Hospital Safety Grade website for Good Samaritan Medical Center. The page features a detailed table of safety measures. The table has the following columns: Measure, The Hospital's Score, Worst Performing Hospital, Avg. Performing Hospital, Best Performing Hospital, Data Source, and Time Period Covered. The table lists various safety measures such as 'Dangers: object left in patient's body', 'Air or gas bubble in the blood', 'Patient falls and injuries', etc. A red box highlights a link at the bottom of the table: 'For a full description of the methodology, click here.'

Measure	The Hospital's Score	Worst Performing Hospital	Avg. Performing Hospital	Best Performing Hospital	Data Source	Time Period Covered
Dangers: object left in patient's body What's This?	0.000	0.027	0.014	0.000	CMS	01/01/2021 - 06/30/2023
Air or gas bubble in the blood What's This?	0.000	2.890	0.002	0.000	CMS	01/01/2021 - 06/30/2023
Patient falls and injuries What's This?	0.769	1.926	0.384	0.000	CMS	01/01/2021 - 06/30/2023
Infection in the blood What's This?	0.000	2.762	0.001	0.000	CMS	01/01/2021 - 12/31/2023
Infection in the urinary tract What's This?	1.967	2.012	0.040	0.000	CMS	01/01/2021 - 12/31/2023
Surgical site infection after colon surgery What's This?	1.079	3.004	0.001	0.000	CMS	01/01/2021 - 12/31/2023
MRI infection What's This?	0.000	2.850	0.719	0.000	CMS	01/01/2021 - 12/31/2023
C. diff infection What's This?	0.250	1.607	0.401	0.000	CMS	01/01/2021 - 12/31/2023
Death from treatable serious complications What's This?	156.08	205.51	177.45	84.64	CMS	01/01/2021 - 06/30/2023
Harmful Events What's This?	1.00	3.10	1.00	0.00	CMS	01/01/2021 - 06/30/2023
Dangerous bad scores What's This? *	0.42	7.50	0.64	0.00	CMS	01/01/2021 - 06/30/2023
Collapsed lung What's This? *	0.36	0.65	0.25	0.10	CMS	01/01/2021 - 06/30/2023
Falls causing broken hips What's This? *	0.00	0.56	0.29	0.10	CMS	01/01/2021 - 06/30/2023
Bleed Looking What's This? *	3.03	5.53	2.42	1.01	CMS	01/01/2021 - 06/30/2023
Kidney injury after surgery What's This? *	1.09	4.60	1.69	0.74	CMS	01/01/2021 - 06/30/2023
Serious breathing problem What's This? *	9.96	57.60	10.53	1.54	CMS	01/01/2021 - 06/30/2023
Dangerous blood clot What's This? *	4.95	8.15	3.90	1.56	CMS	01/01/2021 - 06/30/2023
Serious bleeding after surgery What's This? *	0.01	12.56	5.63	1.95	CMS	01/01/2021 - 06/30/2023
Surgical wound splits open What's This? *	1.70	4.00	1.87	1.13	CMS	01/01/2021 - 06/30/2023
Accidental cuts and tears What's This? *	0.04	2.41	0.89	0.28	CMS	01/01/2021 - 06/30/2023

* This measure is a part of the Harmful Events Composite and is not used for scoring.

Process measures include the management structures and procedures a hospital has in place to protect patients from errors, accidents, and injuries.

Measure	The Hospital's Score	Worst Performing Hospital	Avg. Performing Hospital	Best Performing Hospital	Data Source	Time Period Covered
Doctors order medications through a computer What's This?	15	15	80.23	100	Imputation Model Applied	Not Applicable
Safe medication administration What's This?	25	25	81.87	100	Imputation Model Applied	Not Applicable
Specialty-trained doctors care for ICU patients What's This?	5	5	65.15	100	Imputation Model Applied	Not Applicable
Effective leadership to prevent errors What's This?	Declined to Report	9.23	117.49	120.00	2024 Leapfrog Hospital Survey	2024
Staff work together to prevent errors What's This?	Declined to Report	0.00	116.85	120.00	2024 Leapfrog Hospital Survey	2024
Nursing and Bedside Care for Patients What's This?	Declined to Report	15	77.87	100	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023
Handwashing What's This?	15	15	74.40	100	Imputation Model Applied	Not Applicable
Communication with nurses What's This?	84	73	90.19	97	CMS	01/01/2021 - 12/31/2023
Communication with doctors What's This?	86	73	89.91	97	CMS	01/01/2021 - 12/31/2023
Responsiveness of hospital staff What's This?	72	55	81.63	95	CMS	01/01/2021 - 12/31/2023
Communication about medicines What's This?	69	55	74.42	93	CMS	01/01/2021 - 12/31/2023
Communication about discharge What's This?	76	67	85.25	97	CMS	01/01/2021 - 12/31/2023

[For a full description of the methodology, click here.](#)

The Leapfrog Hospital Safety Grade is a public service provided by The Leapfrog Group, an independent nonprofit organization committed to driving quality, safety, and transparency in the U.S. health system.

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• Why the Hospital Safety Grade Works

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• How to Use the Grade
• Choosing the Best Hospital
• Lives Lost and Lives Saved
• Frequently Asked Questions

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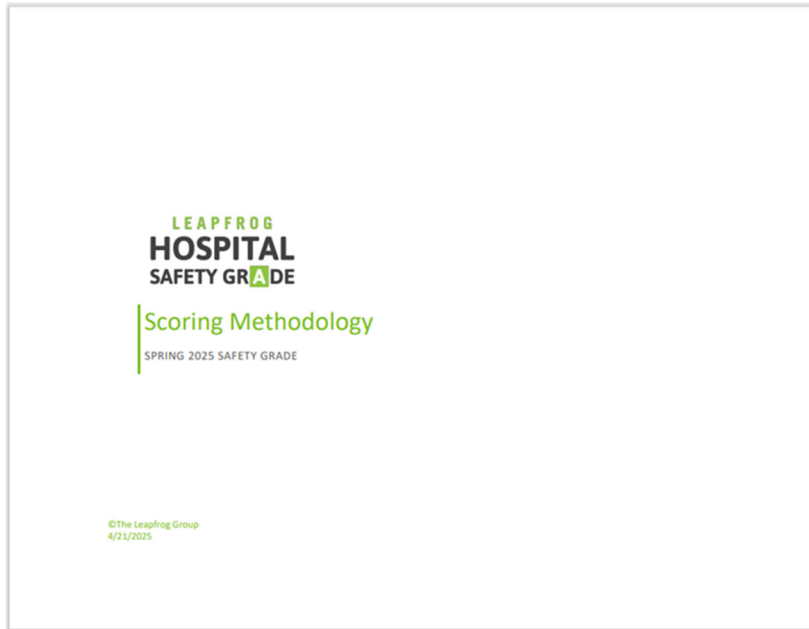
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Source: “Good Samaritan Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/table-details/good-samaritan-medical-center>

Note: This exhibit displays the “Detailed table view” page for Good Samaritan Medical Center. The part of the page marked by the red box shows the “For a full description of the methodology, click here.” link.

Exhibit 16 Steps to Navigate to TLG’s Disclosure in the Methodology Document from a Hospital Safety Grade Page, Step 3

Step 3:
Consumer has to
open the “Scoring
Methodology”
document.



Source: Methodology Document

Note: This exhibit displays the cover page of the methodology document.

Exhibit 17 Steps to Navigate to TLG’s Disclosure in the Methodology Document from a Hospital Safety Grade Page, Step 4

Step 4:
Consumer has to
click on
“Imputation
Method for CPOE,
BCMA, IPS, and
Hand Hygiene.”

LEAPFROG HOSPITAL SAFETY GRADE	
CONTENTS	
What is the Hospital Safety Grade?	3
Eligible Hospitals	3
Measures	4
Measure & Scoring Descriptions	9
Process/Structural Measures	9
Computerized Physician Order Entry (CPOE)	9
Bar Code Medication Administration (BCMA)	9
ICU Physician Staffing (IPS)	10
National Quality Forum (NQF) Safe Practices	11
Total Nursing Care Hours per Patient Day	11
Hand Hygiene	12
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Composites	12
Outcome Measures	13
Hospital-Acquired Conditions	13
Healthcare-Associated Infections	13
AHRQ Patient Safety Indicators (PSI)	14
Using Secondary Data Sources	15
Imputation Method for CPOE, BCMA, IPS, and Hand Hygiene	15
Step 1: Use a Hospital's Most Recent Score on the Measure (Applies to CPOE, IPS, and Hand Hygiene Only)	15
Step 2: Use Imputation Point Assignment (Applies to CPOE, BCMA, IPS and Hand Hygiene)	16
CMS Data For HAIs	17
Scoring Methodology	18
Weighting Individual Measures	18
Evidence	18
Opportunity	18
Impact	18

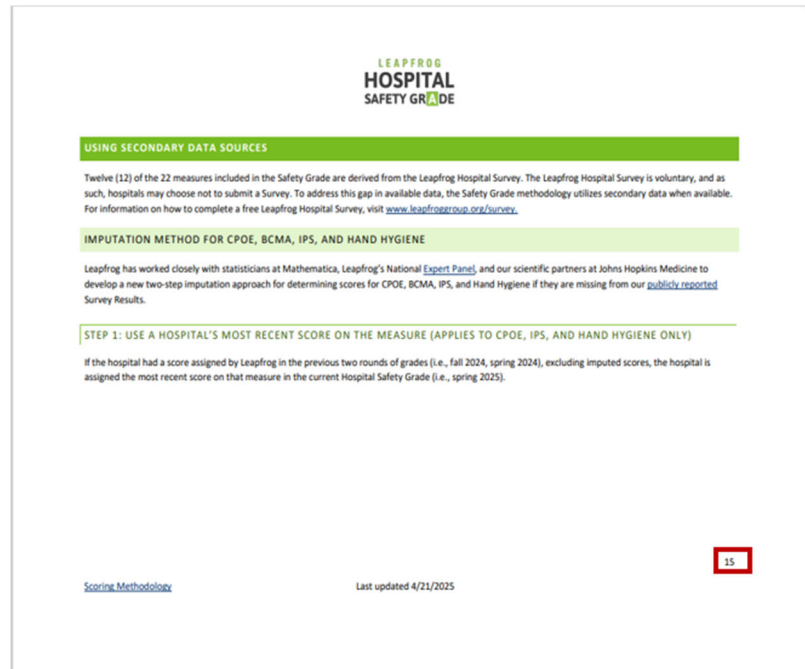
[Scoring Methodology](#) Last updated 4/21/2025 1

Source: Methodology Document

Note: This exhibit displays page 1 of the methodology document, which contains the Table of Contents. The part of the page marked by the red box shows the “Imputation Method for CPOE, BCMA, IPS, and Hand Hygiene” entry.

Exhibit 18 Steps to Navigate to TLG’s Disclosure in the Methodology Document from a Hospital Safety Grade Page, Step 5

Step 5:
Consumer is taken to
page 15 of the “Scoring
Methodology” document.



Source: Methodology Document

Note: This exhibit displays page 15 of the methodology document. The part of the page marked by the red box shows the page number.

Exhibit 19 Steps to Navigate to TLG’s Disclosure in the Methodology Document from a Hospital Safety Grade Page, Step 6

Step 6:
Consumer has
to scroll down
to page 16 of
the “Scoring
Methodology”
document.



STEP 2: USE IMPUTATION POINT ASSIGNMENT (APPLIES TO CPOE, BCMA, IPS AND HAND HYGIENE)

If the hospital does not have historical data from the last two rounds (i.e., fall 2024, spring 2024) of the Safety Grade, the hospital is assigned a point value that is equivalent to receiving “Limited Achievement” for this measure on the Leapfrog Hospital Survey.

Note about IPS: Only hospitals that operate an adult or pediatric medical and/or surgical ICU or neuro ICU are eligible for Step 2 Imputation of the IPS measure. A hospital’s ICU designation (i.e., operating a medical ICU, surgical ICU, or pediatric ICU) is determined from the number of medical, surgical and/or pediatric ICU beds reported in Worksheet S-3 Part 1 of the hospital’s most recent CMS Cost Report. If your hospital does not operate an ICU, but shares a CMS Certification Number with a hospital that does, please [contact the Help Desk](#) immediately if an IPS score was imputed.

Step 2 Imputation Point Assignments

Measure	Leapfrog Hospital Survey Performance Category	Corresponding Safety Grade Measure Score
CPOE	Limited Achievement	15
BCMA	Limited Achievement	25
IPS	Limited Achievement	5
Hand Hygiene	Limited Achievement	15

[Scoring Methodology](#)

Last updated 4/21/2025

16

Source: Methodology Document

Note: This exhibit displays page 16 of the methodology document. The part of the page marked by the red box shows the page number.

E. TLG’s Imputation Disclosures May Negatively Impact Consumers’ Perceptions of Plaintiff Hospitals

85. To the extent consumers read TLG’s imputation disclosures, the language and framing of the disclosure content may cause consumers to form negative perceptions about Plaintiff Hospitals. Decades of research has found that the language used in, and framing of, a message, or the decisions of “what to say, what not to say, and how to say it,” impacts how consumers respond to that message.¹⁶⁵ In this matter, the footnote disclosure is framed such that “the hospital” is the actor or agent in the sentence: “[t]he hospital declined to report their performance on this

¹⁶⁵ Flusberg, S. J., et al. (2024), “The Psychology of Framing: How Everyday Language Shapes the Way We Think, Feel, and Act,” *Psychological Science in the Public Interest*, 25, 3, 105–161 at p. 105, PBHN000003614–70; Tversky, A. and D. Kahneman (1981), “The Framing of Decisions and the Psychology of Choice,” *Science*, 211, 4481, 453–458 at p. 457, PBHN000004280–5; Berger, J. and G. Packard (2023), “Wisdom from Words: The Psychology of Consumer Language,” *Consumer Psychology Review*, 6, 1, 3–16, PBHN000003303–16.

measure.”¹⁶⁶ Such framing is an example of “agentive language,” which includes the use of active voice with an agent, or actor, in the subject of a sentence.¹⁶⁷ Research studying agentive language in the context of accidents has shown that, compared to non-agentive language (e.g., in this case “the data were not available”) such framing can lead consumers to assign more blame to the subject of a sentence.¹⁶⁸ In other words, TLG’s use of agentive language may lead consumers to place the responsibility for missing data on Plaintiff Hospitals.

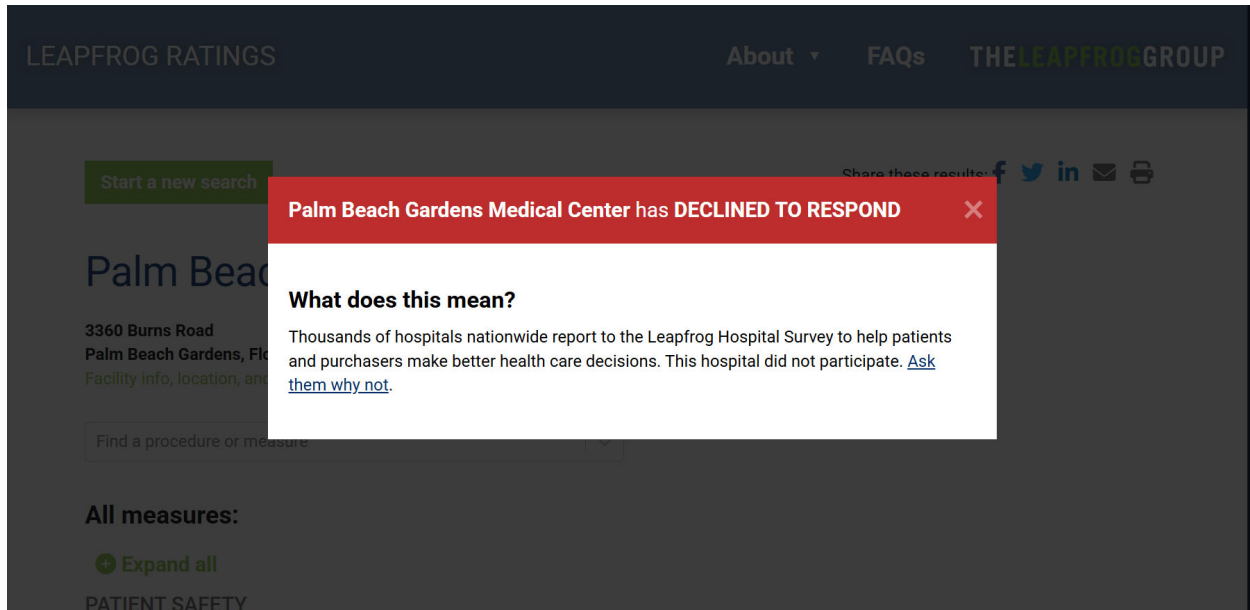
86. As another example, in a disclosure on its leapfroggroup.org, TLG uses even stronger language. A consumer on a Hospital Safety Grade Page can click on “View this hospital’s Leapfrog Hospital Survey Results” to navigate to the hospital’s page on leapfroggroup.org, as shown in Exhibit 8. Upon doing so, a consumer is immediately shown the pop-up in Exhibit 20. The pop-up language tells consumers that hospitals who participate in the survey do so “to help patients and purchasers make better health care decisions” but that “[t]his hospital did not participate.” From this language, consumers may infer that hospitals who choose not to participate are not interested in helping improve patients’ health care decisions. Moreover, TLG also prompts consumers to click on a link that says “[a]sk [the hospital] why not,” implying that the hospital failed to take an action it should have taken. TLG provides consumers who click on the link a draft of a letter requesting the hospital participate in TLG’s survey (Exhibit 21) and noting that hospitals should participate in the survey to “be transparent about its record on quality and safety.”

¹⁶⁶ Emphasis added. See, e.g., Motion to Dismiss, Exhibit 28 (citing “Good Samaritan Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center>), PBHN000002641–3.

¹⁶⁷ Fausey, C. and L. Boroditsky (2010), “Subtle Linguistic Cues Influence Perceived Blame and Financial Liability,” *Psychonomic Bulletin & Review*, 17, 5, 644–650 at p. 644.

¹⁶⁸ Fausey, C. and L. Boroditsky (2010), “Subtle Linguistic Cues Influence Perceived Blame and Financial Liability,” *Psychonomic Bulletin & Review*, 17, 5, 644–650 at p. 646.

Exhibit 20 Pop-Up Shown When the User Navigates from hospitalsafetygrade.org to leapfroggroup.org Using the “View this hospital’s Leapfrog Hospital Survey Results” Link



Source: “Palm Beach Gardens Medical Center,” *The Leapfrog Group*, <https://ratings.leapfroggroup.org/facility/details/10-0176/palm-beach-gardens-medical-center-palm-beach-gardens-fl>

Note: This exhibit displays the pop-up on leapfroggroup.org when the user navigates from the Hospital Safety Grade page for Palm Beach Gardens Medical Center using the “View this hospital’s Leapfrog Hospital Survey Results” link.

Exhibit 21 Draft of Survey Participation Request Letter Provided to Consumers who Click on “Ask them why not” Link on leapfroggroup.org

Date

Hospital CEO

Hospital Name

Hospital Address Line 1

Hospital Address Line 2

Dear [Hospital CEO],

In reviewing the results of the most recent Leapfrog Hospital Survey, I noticed that [Hospital Name] declined to participate. As an active member of this community, it's important to me that my local hospital be transparent about its record on quality and safety. Without that information, how can I determine if [Hospital Name] is the best hospital for me and my family?

I urge you to reconsider this decision and choose to participate in the Leapfrog Hospital Survey. You can visit www.LeapfrogGroup.org for more information.

I look forward to seeing the results of your hospital's performance on the Leapfrog Hospital Survey, and sharing that information with my friends and family.

Thank you for your time,

[Your name]

Source: “Survey Participation Request Letter,” *The Leapfrog Group*,
<https://www.leapfroggroup.org/sites/default/files/Files/Survey%20Participation%20Request%20Letter.docx>

Note: This exhibit displays the draft letter on leapfroggroup.org when the user navigates from the Hospital Safety Grade page for a non-participating hospital using the “View this hospital's Leapfrog Hospital Survey Results” link and then the “Ask them why not” link.

Executed this 7th of August, 2025



Jonah Berger

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Academic Positions

<i>The Wharton School, University of Pennsylvania</i>	
Associate Professor of Marketing (with tenure)	May 2013 –
James G. Campbell, Jr. Assistant Professor of Marketing	July 2010 – May 2013
Assistant Professor of Marketing	July 2007 – June 2010
<i>Cornell NYC Tech, Cornell University</i>	
Visiting Professor of Marketing	July 2014 – June 2015
<i>Fuqua School of Business, Duke University</i>	
Visiting Associate Professor of Marketing	July 2013 – Dec. 2013

Education

Ph.D., Marketing, Stanford University, Graduate School of Business, 2007
B.A., Human Judgment and Decision Making (with Distinction), Stanford University, 2002

Honors and Awards

Sheth Foundation Award, best article published in the *Journal of Marketing* that has made long-term contributions to the field of marketing, 2025
ISSEP General Best Paper Award, 2025
3rd most cited author in top marketing journals in 2024, SMU Analysis
Hunt/Maynard Award Finalist, most significant contribution to marketing theory and thought, *Journal of Marketing*, 2024
Sage 10-Year Impact Award (1 of the 3 most cited articles in all Sage journals in 2012), 2023
Wharton Teaching Excellence Award 2019, 2020, 2021, 2022, 2023
Most cited *Journal of Marketing* article, 2022
Berry-AMA Book Prize Finalist for Best Book in Marketing, 2022
AMA-Sheth Foundation Doctoral Consortium Fellow, 2019, 2020, 2021, 2022
MSI Scholar, 2020
William F. O'Dell Award, *Journal of Marketing Research*, 2017
Outstanding Reviewer Award, *Journal of Consumer Research* 2015–2016
Best 2012 Article Finalist, *Journal of Consumer Research*, 2015
Top 30 Leaders in Business, American Management Association, 2015
Emerald Citations of Excellence, article published in 2012, 2015
Berry-AMA Book Prize for Best Book in Marketing, 2014
Top 10 Most Productive Researchers in Marketing, AMA DocSig 2013–
Most Creative People in Business, Fast Company, 2013
Paul Green Award, *Journal of Marketing Research*, Finalist 2013
Early Career Award, *Association for Consumer Research*, 2013
Early Career Award, *Society for Consumer Psychology*, 2012
Dean's Research Grant, The Wharton School, 2012
Outstanding Reviewer Award, *Journal of Consumer Research* 2010–2011
Outstanding Reviewer Award, *Journal of Consumer Psychology*, 2010–2011
“Iron Prof” Award for “Awesome Faculty Research,” The Wharton School, 2011

MBA Teaching Commitment and Curricular Innovation Award, The Wharton School, 2011
Dean's Research Grant, The Wharton School, 2011
Young Scholars Program, Marketing Science Institute, 2011
Alex Panos Research Grant, The Wharton School, 2011
Journal of Consumer Research Best 2007 Article Award Finalist, 2010
James G. Campbell, Jr. Memorial Term Professorship, 2010
Dean's Research Grant, The Wharton School, 2010
AMA-Sheth Foundation Doctoral Consortium Fellow, 2006
Society for Consumer Psychology, Best Student Paper Award (Honorable Mention), 2006
Management Science Institute/JCP Research Competition (Honorable Mention), 2004
Jaedeke Scholar, Stanford Graduate School of Business, 2003

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2. "Casting a Wider Net," *forthcoming, Current Directions in Psychological Science*.
3. Berger, Jonah (2025), "What Gets Shared and Why? Interpersonal Communication and Word of Mouth," *Annual Review of Psychology*.
4. Packard, Grant, Yang Li, and Jonah Berger (2024), "When Language Matters," *Journal of Consumer Research*, 51(3), 634–653.
5. Packard, Grant, and Jonah Berger (2024), "The Emergence and Evolution of Consumer Language Research," *Journal of Consumer Research*, 51(1), 42–51.
6. Berger, Jonah, and Olivier Toubia (2024), "The Topography of Thought," *Proceedings of the National Academy of Sciences Nexus*, 3(5), 163.
 - Featured in *Nature*
7. Weingarten, Evan, and Jonah Berger (2024), "Discussing Proximal Pasts and Far Futures," *Journal of Consumer Psychology*, 34(1), 6–17.
 - Lead article
8. Oba, Demi and Jonah Berger (2024), "How Communication Mediums Shape the Message," *Journal of Consumer Psychology*, 34(3), 406–424.
9. Packard, Grant, Jonah Berger, and Reihane Boghrati (2023) "How Verb Tense Shapes Persuasion," *Journal of Consumer Research*, 50(3), 645–660.
 - Featured in HBR's IdeaWatch
10. Cascio-Rizzo, Giovanni Luca, Jonah Berger, Rumen Pozharliev, and Matteo De Angelis (2023), "How Sensory Language Shapes Consumer Responses to Influencer-Sponsored Content," *Journal of Consumer Research*, 50(4), 810–825.
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 - First two authors contributed equally
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 - **William F. O’Dell Award, Journal of Marketing Research, 2017**
 - **Paul Green Award Finalist, Journal of Marketing Research, 2013**
 - **Emerald Citations of Excellence, 2015**
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 - **Best 2012 Article Finalist, Journal of Consumer Research**
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 - **Featured in *Nature* (2008). 453, 1197.**
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 - **Best 2007 Article Finalist, *Journal of Consumer Research***
 - **3rd highest cited JCR paper, 2011–2014**
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 - **Featured in Editor's Choice section of *Science* (2007). 316, 1814.**
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80. Berger, Jonah and Chip Heath (2005), "Idea Habitats: How the Prevalence of Environmental Cues Influences the Success of Ideas," Cognitive Science, 29, 195–221. (Lead Article)

Books, Chapters, and Other Publications

81. Berger, Jonah (2023), *Magic Words: What to Say to Get Your Way*, Harper Collins.
 - **New York Times and Wall Street Journal Bestseller**
82. Berger, Jonah (2020), *The Catalyst: How to Change Anyone's Mind*, Simon & Schuster.
 - **New York Times and Wall Street Journal Bestseller**
 - Berry-AMA Book Prize Finalist for Best Book in Marketing, 2022
83. Berger, Jonah (2016), *Invisible Influence: The Hidden Forces that Shape Behavior*, Simon & Schuster.
 - **New York Times and Wall Street Journal Bestseller**
84. Berger, Jonah (2013), *Contagious: Why Things Catch On*, Simon & Schuster.

- **New York Times, Wall Street Journal Bestseller, Amazon Best Business Book of 2013, AMA-Berry Book Prize for Best Book in Marketing 2014**
 - **Millions of copies in print in over 35 languages**
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86. Berger, Jonah (2020), “How to Persuade People to Change Their Behavior,” Harvard Business Review. April 20
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Working Papers

96. Van Zant, Alex, Jonah Berger, Grant Packard, and Harry Wang, “The Power of Pausing,” *Under 3rd Review*.
97. A Machine Learning Approach to examine Originality of user-generated Content from TikTok. *Under 2nd Revision*. Best in track paper, Big Data, Analytics, AI & Machine Learning track, Winter AMA
98. Cascio-Rizzo, Giovanni Luca, Jonah Berger, and Mi Zhou, “How Hand Movements Shape Communication’s Impact,” *Under 2nd Review*.
99. Oba, Demi and Jonah Berger, How Hedges Impact Persuasion, *Under Revision*.
100. Cascio-Rizzo, Giovanni Luca, Jonah Berger, and Matt Rocklage “Speaking, Writing, and the Expression of Certainty,” *Under Review*.

101. Sepehri, Amir, Reihane Boghrati, and Jonah Berger, “Measuring and Mitigating Bias in Machine Learning,” *Under Review*.
Winner, EMAC-Sheth Foundation Sustainability Research Competition 2022
102. Cascio-Rizzo, Giovanni Luca, and Jonah Berger, “How Speaking Rate Shapes Consumer Response,” *Under Review*.
 - Featured in *Harvard Business Review*
103. What Drives Virtual Influencer’s Impact? *Under Review*
104. Visual Similarity to the Past, *Under Review*.
105. Boghrati, Reihane and Jonah Berger, “What Drives Longer Conversations?” *Under Review*.
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111. Reverse Diffusion.
112. Disposal in Response to Social Rejection
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114. Iyengar, Raghu and Jonah Berger, “How the Quantity and Timing of Social Influence Impact Product Adoption”
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Service

Global Youth Program Advisory Committee 2022–
MBA Curriculum Committee, 2021–
Organizer, Insights from Text Conference, 2017–
Wharton Digital Press Faculty Advisory Board
MBA Executive Committee, The Wharton School, July 2017–2020
Undergraduate Marketing Coordinator, The Wharton School, 2016–

Co-Founder, Technology and Behavioral Science Initiative, The Wharton School, 2015–
University of Pennsylvania Faculty Senate Executive Committee October 2018–2020
PhD Committee, The Wharton School, Sept 2009–July 2015
Curriculum Review Committee, The Wharton School, Sept 2015–July 2016
MBA Class of 2014 Convocation Speaker 2012
Dean’s Advisory Council, The Wharton School, Sept 2011–July 2012
Decision Process Seminar, Co-Organizer, The Wharton School, Sept 2008–July 2010
Course Development: MKTG 228/728 (Contagious: How Products, Ideas, and Behaviors Catch On)

Editorial Activities

Co-Editor, Special Issue of *Journal of Consumer Psychology* on Consumer Insights from Text Analysis, Oct 2023
Associate Editor, *Journal of Marketing*, June 2018 – Dec 2023
Associate Editor, *Journal of Marketing Research*, July 2012 - 2020
Associate Editor, Special Issue on Social Media, *Information Systems Research*, 2011
Guest Editor, *Journal of Marketing*
Guest Editor, *Proceedings of the National Academy of Sciences*

Editorial Review Boards: *Journal of Marketing Research*, *Journal of Marketing*, *Journal of Consumer Psychology*, *Research, Marketing Science*

Program Committees: *Association for Consumer Research* (2009, 2011, 2013, 2014, 2020, 2024, 2025, Knowledge Forum Chair, 2023), *Society for Consumer Psychology* (2008, 2013, 2014, 2020)

Selected Ad-Hoc Reviewing

Journal of Personality and Social Psychology, *Journal of Experimental Social Psychology*, *Journal of Personality*, *Journal of Decision Making*, *Organizational Behavior and Human Decision Processes*, *Trends in Cognitive Science*, *Journal of Experimental Psychology: Applied*, *International Journal of Research in Marketing*, *Psychological Science*, *Personality and Social Psychology Bulletin*, *Society for Judgment and Decision Making Conference*, *PLoS ONE*, *Social and Personality Psychology Compass*, *Management Science*, *Proceedings of the National Academy of Sciences*, *Evolution and Human Behavior*, *Journal of Behavioral Decision Making*, *Advances in Complex Systems*, *Nature: Human Behavior*, *Self and Identity*

Advising

Giovanni Luca Cascio-Rizzo (co-advisor)
Demi Oba (co-advisor)
Ike Silver (committee member)
Reihane Boghrati (post doc advisor)
Ezgi Akpinar (co-advisor) winner, 2014 McKinsey Dissertation Award
Zoey Chen (committee member)
Cindy Chan (committee member)
Amit Bhattacharjee (committee member)

Jonah Berger
Prior Testimony in the Last Four Years

I have given expert testimony at deposition and/or at trial in the following matters:

1. *In Re: Duramax Diesel Litigation*, United States District Court for the Eastern District of Michigan, Case No. 1:17-cv-11661-TLL-PTM, and related matters. Deposition testimony on March 18, 2022.
2. *JUUL Labs, In. Marketing, Sales Practices, and Products Liability Litigation*, United States District Court, Northern District of California, File No.: 19-md-02913-WHO. Deposition testimony on October 7, 2021, November 30, 2021, and May 19, 2022.
3. *J. Hart et al. v. TWC Product and Technology LLC*, United States District Court, Northern District of California, Case No. 4:20-cv-3842-JST. Deposition testimony on June 3, 2022.
4. *J. Ciccio et al. v. SmileDirectClub, Inc.*, United States District Court, Middle District of Tennessee, Nashville Division, Case No. 3:19-cv-00845. Deposition testimony on July 25, 2022.
5. *Walter Peters v. Apple, Inc.*, Superior Court of the State of California, County of Los Angeles, Case No. 19STCV21787. Deposition testimony on August 26, 2022.
6. *State of Minnesota, by its Attorney General, Keith Ellison vs. Juul Labs Inc.*, Fourth Judicial District Court, State of Minnesota, County of Hennepin, Court File No. 27-CV-19-19888. Deposition testimony on September 30, 2022.
7. *City of Chicago v. Juul Labs, Inc. et al.*, In the Circuit Court of Cook County, Illinois County Department, Chancery Division, Case No. 2020CH04183. Deposition testimony on October 19, 2022.
8. *Commonwealth of Kentucky, ex rel. Daniel Cameron, Attorney General v. Johnson & Johnson, et al.*, Commonwealth of Kentucky, Franklin Circuit Court, Civil Action No. 16-CI-867. Deposition testimony on November 2, 2022.
9. *District of Columbia v. Juul Labs, Inc. et al.*, In the Superior Court of the District of Columbia, Civil Division, Case No. 2019-CA-007795-B. Deposition testimony on February 7, 2023.
10. *Yuga Labs, Inc. v. Ripps, et al.*, United States District Court, Central District of California, Case No. 2:22-cv-04355. Deposition testimony on March 9, 2023. Trial testimony on July 31, 2023.
11. *Smartmatic USA Corp., Smartmatic International Holding B.V., and SGO Corporation Limited v. Newsmax Media, Inc.*, Superior Court of the State of Delaware, Case No. N21C-11-028 EMD. Deposition testimony on February 12, 2024.

12. *In Re: Qualcomm Incorporated Securities Litigation*, United States District Court, Southern District of California, Civil Action No. 3:17-cv-00121-JOMSB. Deposition testimony on February 20, 2024.
13. *Smartmatic USA Corp., Smartmatic International Holding B.V., and SGO Corporation Limited v. Fox Corporation, Fox News Network LLC, Lou Dobbs, Maria Bartiromo, Jeanine Pirro, and Rudolph Giuliani*, Supreme Court of the State of New York, County of New York, Index No. 151136/2021. Deposition testimony on May 22, 2024.
14. *Smartmatic USA Corp., Smartmatic International Holding B.V., and SGO Corporation Limited v. Michael J. Lindell and My Pillow, Inc.*, United States District Court, District of Minnesota, Case No. 22-cv-0098-WMW-JFD. Deposition testimony on August 12, 2024.
15. *Virtru Corporation v. Microsoft Corporation*, United States District Court for the Western District of Washington at Seattle, Case No. 2:23-cv-00872-JNW. Deposition testimony on November 19, 2024.
16. *Jane Doe, Janet Roe, and Janice Coe v. Netflix, Inc.; Netflix Worldwide Entertainment, LLC; and Realhouse Productions LLC*, United States District Court Southern District of Indiana, Indianapolis Division, Case 1:22-cv-01281-TWP-MJD. Trial testimony on December 4, 2024.
17. *In Re: Google Digital Advertising Antitrust Litigation*, United States District Court for the Southern District of New York, Case No. 1:21-md-3010 (PKC). Deposition testimony on March 6, 2025.
18. *In Re: Apple iPhone Antitrust Litigation*, United States District Court for the Northern District of California, Case No. 4:11-cv-06714-YGR. Deposition testimony on April 3, 2023 and July 1, 2025.

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- Declaration of Professor Sean Nicholson, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526-DMM, May 17, 2025
- Expert Report of Professor Sean Nicholson, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526-DMM, August 7, 2025

Legal Documents

- Complaint and Demand for Jury Trial, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526, April 30, 2025
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Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526-DMM, July 11, 2025, with Exhibits

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Other Documents

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**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION**

GOOD SAMARITAN MEDICAL CENTER
INC., DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. D/B/A PALM BEACH
GARDENS MEDICAL CENTER, ST.
MARY'S MEDICAL CENTER, INC., AND
WEST BOCA MEDICAL CENTER, INC.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

Case No. 9:25-CV-80526

Supplemental Expert Report of Jonah Berger, Ph.D.

August 21, 2025

Table of Contents

I.	Background and Assignment	1
II.	Summary of Opinions	2
III.	The Vast Majority of Users who Visited Plaintiff Hospitals’ Safety Grade Pages Did Not Download TLG’s Fall 2024 or Spring 2025 “Scoring Methodology” Documents	3
IV.	Views of Plaintiff Hospitals’ Safety Grades Increased After TLG’s Publicized the Releases of its Fall 2024 and Spring 2025 Hospital Safety Grades.....	7

I. Background and Assignment

1. On August 7, 2025, I submitted an expert report (“Berger Report”) in the above-captioned matter.¹ A summary of my qualifications, my compensation in this matter, and a list of my prior testimony are included in the Berger Report. A list of additional materials I have considered since my initial report is attached as **Appendix A**.

2. In the Berger Report, I was asked to assess whether, and in what ways, the publication or repeated publication of low or failing TLG Hospital Safety Grades may impact consumers’ perceptions of and decisions to seek care at the five Plaintiff Hospitals.² I was also asked to assess the extent to which TLG’s imputation disclosures³ would be expected to affect consumers’ understanding of TLG’s imputation methodology and its impact on TLG’s Hospital Safety Grades for non-participating hospitals.⁴ In setting forth my opinions in the Berger Report, I noted that “the parties are continuing to produce documents and evidence in this case” and that “I reserve the right to adjust my opinions based on my review of documents recently produced or that will be produced in this litigation.”⁵ I understand that TLG produced excerpts of website analytics data from its Google Analytics account for hospitalsafetygrade.org on August 5, 2025 (“TLG’s Website Analytics Data”), such that I did not have the opportunity to meaningfully review the data prior to submission of the Berger Report. In this supplemental report, I have been asked to review and evaluate TLG’s recently produced data, including its Website Analytics Data.

3. I reserve the right to supplement or amend my opinions should new information become available.

¹ Expert Report of Jonah Berger, Ph.D., *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526, August 7, 2025 (“Berger Report”).

² Berger Report, ¶¶ 8, 12.

³ In the Berger Report, I define “imputation disclosures” as the notes and documentation on hospitalsafetygrade.org and leapfroggroup.org cited in TLG’s Motion to Dismiss, in which TLG purports to disclose its imputation methodology. In my analysis in Section VIII of the Berger Report, I also include exhibits to Plaintiffs’ Motion for Preliminary Injunction. *See* Berger Report ¶¶ 9, 72.

⁴ Berger Report, ¶ 12.

⁵ Berger Report, ¶ 13, footnote 14.

II. Summary of Opinions

4. In the Berger Report, I presented evidence that TLG has repeatedly presented its Hospital Safety Grades as measuring patient safety and has highlighted the potential harm that patients may experience from choosing a low-graded hospital, including with statements such as “patients are twice as likely to die ... at a ‘C,’ ‘D,’ or ‘F’ hospital than an ‘A’ hospital.”⁶ Among other things, I concluded that, while TLG purports to provide disclosures about its practice of assigning the minimum score on its imputed measures for non-participating hospitals,⁷ TLG’s purported disclosures are unlikely to help consumers understand what TLG does and the impact this practice has on non-participating hospitals’ Safety Grades.⁸ In fact, I showed evidence that, in some content on hospitalsafetygrades.org, TLG explicitly downplays the impact of this practice on the overall Hospital Safety Grades it assigns to hospitals.⁹

5. In the Berger Report, I analyzed TLG’s purported disclosures and found that only one—TLG’s Spring 2025 “Scoring Methodology” document”—both states that TLG assigns the minimum score on the imputed measures and can be accessed from TLG’s Hospital Safety Grade Pages.¹⁰ I also explained that many consumers are unlikely to see, let alone read, TLG’s Spring 2025 “Scoring Methodology” document.¹¹ TLG’s Website Analytics Data corroborates this conclusion. The data shows that only 3% of users who navigated to Plaintiff Hospitals’ Safety Grade Pages even downloaded, and thus were even *potentially* exposed to the disclosure in, either the Spring 2025 “Scoring Methodology” document or the Fall 2024 “Scoring Methodology” document (a previous version of the document). As discussed in the Berger Report, once these users downloaded the “Scoring Methodology” document, they would need to navigate to page 16 to access the language that discusses TLG’s practice of assigning the minimum score on the

⁶ Berger Report, ¶ 45.

⁷ I understand that Plaintiffs allege and Professor Nicholson finds that TLG’s Hospital Safety Grades for non-participating hospitals can be negatively impacted by TLG’s practice of assigning the minimum score on the imputed measures. *See* Berger Report, ¶ 77.

⁸ Berger Report, Section VIII.

⁹ Berger Report, ¶ 80.

¹⁰ Berger Report, ¶¶ 66, 72–73, Section VIII.D. My understanding of which pages can be accessed from a TLG Hospital Safety Grade Page is based on a review of the website as of July 30, 2025. *See* Berger Report, footnote 143.

¹¹ Berger Report, Section VIII.D.

imputed measures.¹² Consequently, it is unlikely that all 3% of users were exposed to, let alone read, the relevant language in these documents.

6. In the Berger Report, I also explained that TLG’s “D” or “F” Hospital Safety Grades for Plaintiff Hospitals likely deter consumers from choosing the hospitals.¹³ As part of this conclusion, I explained that, when consumers are making healthcare decisions, it can be difficult for consumers to review, process, and evaluate available information on the variety of attributes that differentiate hospitals.¹⁴ However, consumers typically engage in some level of research online as they make healthcare decisions.¹⁵ I explained that TLG has widely publicized its Fall 2024 and Spring 2025 Hospital Safety Grades releases and that, among other publicity, each release was covered in over 700 online articles, making it more likely that consumers would see the grades, including TLG’s “D” or “F” grades for Plaintiff Hospitals, during their research.¹⁶ TLG’s Website Analytics Data is consistent with this conclusion. The data shows that views of Hospital Safety Grade Pages on hospitalsafetygrade.org increased sharply after TLG released its Fall 2024 and Spring 2025 Hospital Safety Grades. Indeed, compared to all other months between May 15, 2024 and July 14, 2025, views across all hospitals’ Safety Grade Pages were four times higher, on average, in months when TLG released its Fall 2024 and Spring 2025 Hospital Safety Grades. Views across Plaintiff Hospitals’ Safety Grade Pages, specifically, were five times higher during the same months.

III. The Vast Majority of Users who Visited Plaintiff Hospitals’ Safety Grade Pages Did Not Download TLG’s Fall 2024 or Spring 2025 “Scoring Methodology” Documents

7. I concluded in the Berger Report that while TLG purports to disclose its imputation methodology on its websites, TLG’s imputation disclosures are unlikely to help consumers understand that TLG assigns the minimum score on the imputed measures and the impact this methodology has on non-participating hospitals’ Safety Grades.¹⁷ In particular, I found that TLG’s footnote disclosure omits language about TLG’s practice of assigning the minimum score on the

¹² Berger Report, ¶ 83.

¹³ Berger Report, Section VI.

¹⁴ Berger Report, ¶ 33.

¹⁵ Berger Report, ¶ 33.

¹⁶ Berger Report, ¶ 34.

¹⁷ Berger Report, Section VIII.

imputed measures.¹⁸ I also concluded that many consumers are unlikely to see, let alone read, the Spring 2025 “Scoring Methodology” document, which is the only disclosure that both states TLG assigns the minimum score on the imputed measures and that can be accessed from TLG’s Hospital Safety Grade Pages.¹⁹ As discussed below, TLG’s Website Analytics Data corroborates this conclusion. Only a small proportion of users who visited Plaintiff Hospitals’ Safety Grade Pages even downloaded, and thus were even *potentially* exposed to the disclosure in, either the Spring 2025 “Scoring Methodology” document or the Fall 2024 “Scoring Methodology” document (a previous version of the document).

8. Website owners like TLG use website analytics data, including data from Google Analytics, to understand how users engage with and navigate through their sites.²⁰ This data may record measures such as the number of times a page is loaded, how often links are clicked, and the order in which users visit different pages on a website.²¹

9. TLG’s Website Analytics Data tracks how users interact with each Plaintiff Hospital’s Safety Grade Page on hospitalsafetygrade.org, including the total number of users who navigated to each page.²² TLG’s Spring 2025 “Scoring Methodology” document is accessible from a Hospital Safety Grade Page by navigating to the Detailed Table View of the hospital’s grade and then clicking on a link to download the document.²³ Accordingly, TLG’s Website Analytics Data not only shows the number of users who visited each Plaintiff Hospital’s Safety Grade Page, but also identifies how many of those users accessed the Detailed Table View or downloaded either

¹⁸ Berger Report, ¶¶ 65–66, Section VIII.C.

¹⁹ Berger Report, ¶¶ 72–74, Section VIII.D. I referred to the Spring 2025 “Scoring Methodology” document as the “methodology document” in the Berger Report. My understanding of which pages can be access from a TLG Hospital Safety Grade Page is based on a review of the website as of July 30, 2025. See Berger Report, footnote 143.

²⁰ “The Value of Digital Analytics,” *Google*, <https://support.google.com/analytics/answer/12159453>, PBHN000009892–3; “[GA4] Find Your Way Around Analytics,” *Google*, <https://support.google.com/analytics/answer/9367631>, PBHN000009919–20.

²¹ See “[GA4] Introducing the Next Generation of Analytics, Google Analytics 4,” *Google*, <https://support.google.com/analytics/answer/10089681>, PBHN000009921–2; “[GA4] About Events,” *Google*, <https://support.google.com/analytics/answer/9322688>, PBHN000009905–7; “[GA4] Automatically Collected Events,” *Google*, <https://support.google.com/analytics/answer/9234069>, PBHN000009908–14.

²² “Users” in TLG’s Website Analytics Data represent “active users,” where “active” indicates users who engaged with the page in the specified date range. “[GA4] Understand User Metrics,” *Google*, <https://support.google.com/analytics/answer/12253918>, PBHN000009923–4.

²³ Berger Report, ¶ 83. Clicking the link to the document represents a download. See “[GA4] Enhanced Measurement Events,” *Google*, <https://support.google.com/analytics/answer/9216061>, PBHN000009915–8.

the Spring 2025 “Scoring Methodology” document, which is the subject of my analysis in the Berger Report, or a previous version, the Fall 2024 “Scoring Methodology” document.²⁴

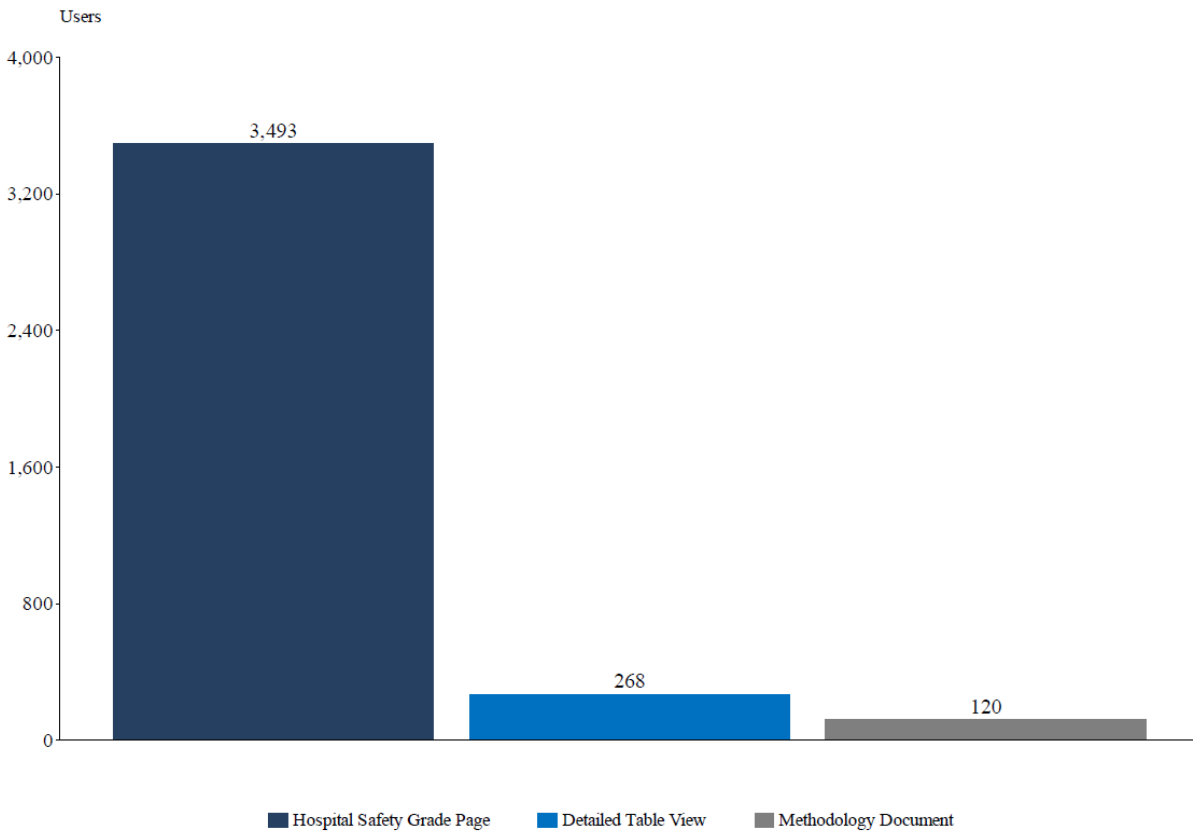
10. TLG’s Website Analytics Data shows that only a very small percentage of users who visited a Plaintiff Hospital’s Safety Grade Page downloaded the Fall 2024 “Scoring Methodology” or Spring 2025 “Scoring Methodology” document. Exhibit 1 presents the number of users who visited a Plaintiff Hospital’s Safety Grade Page between November 15, 2024 and August 4, 2025 (the end of the last month of data) and, of those, the number that accessed the Detailed Table View on that Plaintiff Hospital’s Safety Grade Page or downloaded either methodology document.²⁵ For example, if a user visited the Hospital Safety Grade Page for Delray Medical Center and, at some point after, visited the Detailed Table View Page for Delray Medical Center’s Hospital Safety Grade, that user would be counted in both the “Hospital Safety Grade Page” and “Detailed Table View” bars. While 3,493 users visited a Plaintiff Hospital’s Safety Grade Page, only 268 (8%) of these users also navigated to that Plaintiff Hospital’s Detailed Table View and only 120 (3%) downloaded either methodology document.²⁶

²⁴ The data records the number of active users who completed each action. The active users who downloaded either methodology document did not necessarily visit the Detailed Table View and vice versa.

²⁵ Users who viewed multiple Plaintiff Hospitals’ Safety Grade Pages are counted multiple times.

²⁶ TLG’s Website Analytics Data also records the total number of downloads for files on hospitalsafetygrade.org. The Fall 2024 “Scoring Methodology” and Spring 2025 “Scoring Methodology” documents were downloaded a total of 6,680 times sitewide from November 15, 2024 to August 5, 2025. See Workpaper 1. By comparison, Hospital Safety Grade Pages were viewed a total of 748,313 times sitewide across the same time period. See Workpaper 2. The Fall 2024 and Spring 2025 Methodology Documents were available at multiple URLs during this time period:
<https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025.pdf>,
<https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025-1.pdf>,
<https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025-2.pdf>,
<https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024.pdf>,
<https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024-1.pdf>. See PBHN000003012–40; PBHN000009808–36; PBHN000009837–65; PBHN000003044–69; PBHN000009866–91. In the Berger Report, I also discuss two additional documents which contain language about TLG’s minimum score assignment: (1) The “Fall 2024 Methodology Updates” document and (2) the “2025 Leapfrog Hospital Survey.” See Berger Report, ¶ 72. The “2025 Leapfrog Hospital Survey” is not on the hospitalsafetygrade.org website and thus not included in TLG’s Website Analytics Data, which only captures hospitalsafetygrade.org analytics. In addition, the “Fall 2024 Methodology Updates” document does not appear in the data recording downloads for the November 15, 2024–August 5, 2025 period.

Exhibit 1 Number of Users who Navigated to Plaintiff Hospitals' Safety Grade Pages, the Detailed Table Views for Plaintiff Hospitals, and Downloaded the Methodology Document



Source: LEAPFROG02864707; LEAPFROG02864708; LEAPFROG02864711; LEAPFROG02864710; LEAPFROG02864714; LEAPFROG02864713; LEAPFROG02864716; LEAPFROG02864718; LEAPFROG02864721; LEAPFROG02864720

Note: This exhibit displays the total count of active users who visited a Plaintiff Hospital's Safety Grade Page between November 15, 2024, the day the Fall 2024 Hospital Safety Grades were released, and August 4, 2025, the end of the last day of the data underlying this analysis, and the proportion of those active users that navigated to the Detail Table Page for that Plaintiff Hospital or downloaded either the Fall 2024 or Spring 2025 "Scoring Methodology" document. Users who visited multiple Plaintiff Hospitals' Safety Grade Pages are counted multiple times.

11. Even after downloading the document, additional steps are required to view the language that discusses TLG's practice of assigning the minimum score on the imputed measures, which is on page 16 of the Spring 2025 "Scoring Methodology" document, as discussed in the Berger Report.²⁷ Consequently, it is unlikely that all of these 3% of users were exposed to, let alone read, the relevant language in these documents.

²⁷ Berger Report, Section VIII.D.

12. In sum, evidence in TLG's Website Analytics Data is consistent with my conclusions in the Berger Report that many consumers are unlikely to read TLG's Spring 2025 "Scoring Methodology" document. Indeed, TLG's Website Analytics Data shows that only a small proportion of users who visited Plaintiff Hospitals' Safety Grade Pages even downloaded, and thus were even *potentially* exposed to the disclosure in, either the Spring 2025 "Scoring Methodology" document or the Fall 2024 "Scoring Methodology" document.

IV. Views of Plaintiff Hospitals' Safety Grades Increased After TLG's Publicized the Releases of its Fall 2024 and Spring 2025 Hospital Safety Grades

13. In the Berger Report, I also explained that TLG's "D" or "F" Hospital Safety Grades for Plaintiff Hospitals likely deter consumers from choosing these hospitals.²⁸ As part of this conclusion, I explained that choosing a hospital is often a complex decision and, when making healthcare decisions, it can be difficult for consumers to review, process, and evaluate available information on the variety of attributes that differentiate hospitals.²⁹ However, consumers typically engage in some level of research online as they make healthcare decisions.³⁰ I explained that TLG has widely publicized its Fall 2024 and Spring 2025 Hospital Safety Grades releases and that, among other publicity, each grade release was covered in over 700 online articles, making it more likely that consumers would see the grades, including TLG's "D" or "F" grades for Plaintiff Hospitals, during their research.³¹

14. TLG's Website Analytics Data is consistent with this conclusion. According to this data, in the month immediately after TLG undertook its publicizing efforts for each release, views of individual hospitals' Safety Grade Pages on hospitalsafetygrade.org increased, both for all hospitals included in the data and for Plaintiff Hospitals specifically.

15. TLG's Website Analytics Data includes, among other things, the number of views of each hospital's Safety Grade Page on hospitalsafetygrade.org by month.³² The data records the number

²⁸ Berger Report, Section VI.

²⁹ Berger Report, ¶ 33.

³⁰ Berger Report, ¶ 33.

³¹ Berger Report, ¶ 34.

³² LEAPFROG02864692; LEAPFROG02864693; LEAPFROG02864689; LEAPFROG02864699; LEAPFROG02864690; LEAPFROG02864700; LEAPFROG02864691; LEAPFROG02864701; LEAPFROG02864702; LEAPFROG02864703;

of monthly page views for the period between November 15, 2023 and August 5, 2025, where a month is defined as the 15th of one month (e.g. November 15, 2024) to the 14th of the next month (e.g., December 14, 2024).³³

16. Exhibit 2 presents the total views of Hospital Safety Grade Pages on hospitalsafetygrade.org, summed across all hospitals in the data. The exhibit analyzes data from May 15, 2024, the start of the first full month of data after the Spring 2024 grades were released, to July 14, 2025, the end of the last full month of data. The exhibit shows that total views increased sharply after TLG's release and subsequent publicity of its Fall 2024 and Spring 2025 Hospital Safety Grades. Specifically, TLG released its Fall 2024 Hospital Safety Grades on November 15, 2024.³⁴ Views of TLG's Hospital Safety Grade Pages increased sharply from the month of October 15, 2024–November 14, 2024 to the month of November 15, 2024–December 14, 2024. TLG then released its Spring 2025 Hospital Safety Grades on May 1, 2025.³⁵ Views of TLG's Hospital Safety Grade Pages similarly increased sharply from the month of March 15, 2025–April 14, 2025 to the month of April 15, 2025–May 14, 2025. In fact, views in the months in which the Fall 2024 and Spring 2025 Hospital Safety Grades were released were approximately four times higher, on average, than views in other months between May 15, 2024 and July 14, 2025.³⁶

LEAPFROG02864694; LEAPFROG02864695; LEAPFROG02864683; LEAPFROG02864696; LEAPFROG02864684; LEAPFROG02864697; LEAPFROG02864685; LEAPFROG02864686; LEAPFROG02864687; LEAPFROG02864688; LEAPFROG02864698

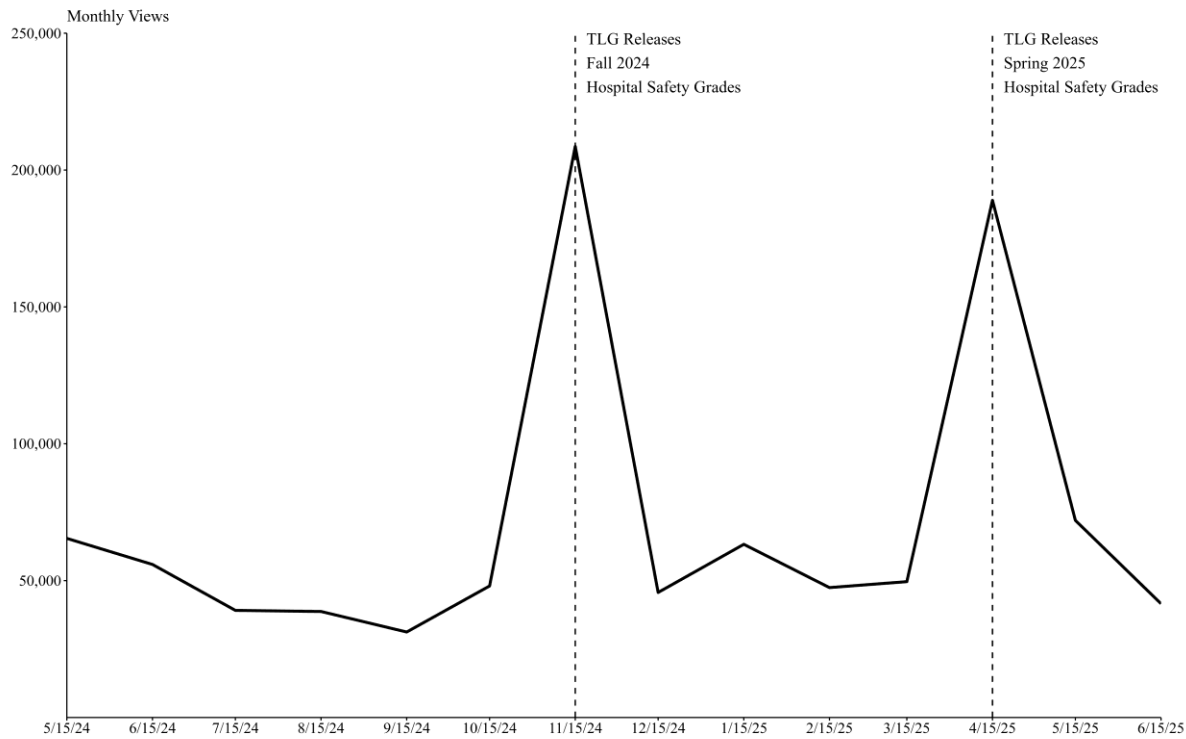
³³ See, e.g., LEAPFROG02864683. One user may view the same webpage multiple times, and each view is counted. See “[GA4] Enhanced Measurement Events,” *Google*, <https://support.google.com/analytics/answer/9216061>, PBHN000009915–8.

³⁴ Berger Report, ¶ 34, footnote 54.

³⁵ Berger Report, ¶ 34.

³⁶ Average views across the two months when TLG released its Fall 2024 and Spring 2025 Hospital Safety Grades (November 15, 2024–December 14, 2024 and April 15, 2025–May 14, 2025) were 198,798. Average views across all other months from May 15, 2024 to July 14, 2025 (the end date of the last full month of data) were 49,840. See Workpaper 3.

Exhibit 2 Total Monthly Views of Hospital Safety Grade Pages, Across All Hospitals



Source: LEAPFROG02864691; LEAPFROG02864701; LEAPFROG02864702; LEAPFROG02864703; LEAPFROG02864694; LEAPFROG02864695; LEAPFROG02864683; LEAPFROG02864696; LEAPFROG02864684; LEAPFROG02864697; LEAPFROG02864685; LEAPFROG02864686; LEAPFROG02864687; LEAPFROG02864698

Note: This exhibit displays the total monthly number of views that all Hospital Safety Grade Pages received on hospitalsafetygrade.org. The monthly views are recorded in periods beginning on the 15th of a month and ending on the 14th of the following month. The exhibit analyzes data from May 15, 2024, the start of the first full month of data after the Spring 2024 grades were released, to July 14, 2025, the end of the last full month of data. The dashed vertical lines indicate the start date for the months during which TLG released its Fall 2024 and Spring 2025 Hospital Safety Grades. TLG released its Fall 2024 Hospital Safety Grades on November 15, 2024 and its Spring 2025 Hospital Safety Grades on May 1, 2025.

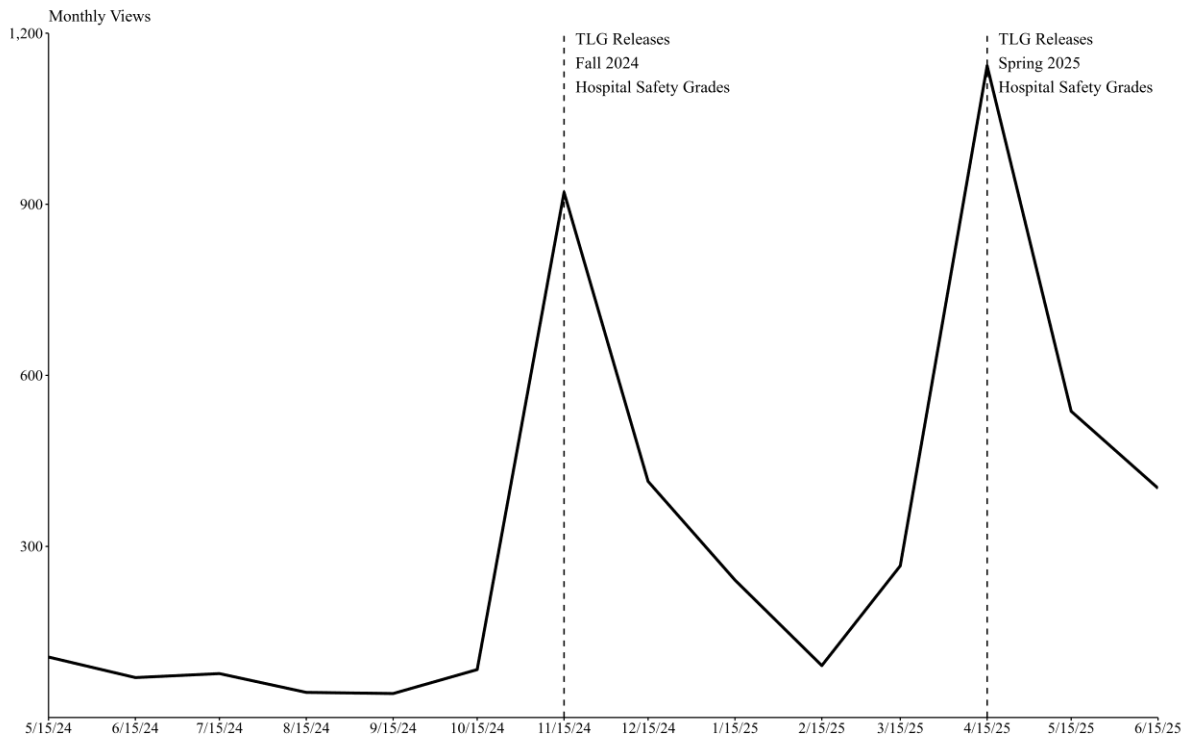
17. Exhibit 3 presents the total views of Plaintiff Hospitals' Safety Grade Pages on hospitalsafetygrade.org, summed across the five Plaintiff Hospitals. As the Exhibit shows, consistent with the results for all hospitals, the total views of Plaintiff Hospitals' Safety Grade Pages increased sharply after TLG's release and subsequent publicity of its Fall 2024 and Spring

2025 Hospital Safety Grades.³⁷ In fact, views for Plaintiff Hospitals' Safety Grade Pages in the months in which the Fall 2024 and Spring 2025 Hospital Safety Grades were released were almost five times higher, on average, than views in other months between May 15, 2024 and July 14, 2025.³⁸

³⁷ My conclusion does not change when I analyze the monthly average number of active users visiting Plaintiff Hospitals' Safety Grade Pages instead of total monthly views. *See* Workpaper 4.

³⁸ Average views for Plaintiff Hospitals across the two months when TLG released its Fall 2024 and Spring 2025 Hospital Safety Grades (November 15, 2024–December 15, 2024 and April 15, 2025–May 14, 2025) were 1,032. Average views for Plaintiff Hospitals across all other months from May 15, 2024 to July 14, 2025 (the end date of the last full month of data) were 198. *See* Workpaper 3. My conclusion does not change when I analyze the monthly average number of active users visiting Plaintiff Hospitals' Safety Grade Pages instead of total monthly views. *See* Workpaper 5.

Exhibit 3 Total Monthly Views of Hospital Safety Grade Pages, Across Plaintiff Hospitals



Source: LEAPFROG02864691; LEAPFROG02864701; LEAPFROG02864702; LEAPFROG02864703; LEAPFROG02864694; LEAPFROG02864695; LEAPFROG02864683; LEAPFROG02864696; LEAPFROG02864684; LEAPFROG02864697; LEAPFROG02864685; LEAPFROG02864686; LEAPFROG02864687; LEAPFROG02864698

Note: This exhibit displays the monthly number of views that Plaintiff Hospitals' Safety Grade Pages received on hospitalsafetygrade.org. The monthly views are recorded in periods beginning on the 15th of a month and ending on the 14th of the following month. The exhibit analyzes data from May 15, 2024, the start of the first full month of data after the Spring 2024 grades were released, to July 14, 2025, the end of the last full month of data. The dashed vertical lines indicate the start date for the months during which TLG released its Fall 2024 and Spring 2025 Hospital Safety Grades. TLG released its Fall 2024 Hospital Safety Grades on November 15, 2024 and its Spring 2025 Hospital Safety Grades on May 1, 2025.

18. In sum, TLG's Website Analytics Data shows that views of Hospital Safety Grade Pages on hospitalsafetygrade.org increased sharply after TLG widely publicized the release of its Fall 2024 and Spring 2025 Hospital Safety Grades. This is consistent with my opinion that TLG's publicity efforts made it more likely that consumers would see the grades.

Executed this 21st of August, 2025

A handwritten signature in dark ink, appearing to read "Jonah Berger", with a long horizontal flourish extending to the right.

Jonah Berger

Documents Considered List

Expert Reports

- Expert Report of Jonah Berger, Ph.D., *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526, August 7, 2025
- Expert Report of Thomas Chakurda, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526-DMM, August 7, 2025

Produced Documents

- LEAPFROG00140378–423
- LEAPFROG00147364–409
- LEAPFROG02864683
- LEAPFROG02864684
- LEAPFROG02864685
- LEAPFROG02864686
- LEAPFROG02864687
- LEAPFROG02864688
- LEAPFROG02864689
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- LEAPFROG02864702
- LEAPFROG02864703
- LEAPFROG02864704
- LEAPFROG02864705
- LEAPFROG02864706
- LEAPFROG02864707
- LEAPFROG02864708
- LEAPFROG02864710
- LEAPFROG02864711
- LEAPFROG02864713
- LEAPFROG02864714
- LEAPFROG02864716
- LEAPFROG02864718
- LEAPFROG02864720
- LEAPFROG02864721

Websites / Online Content

- “[GA4] About Events,” *Google*, <https://support.google.com/analytics/answer/9322688>, PBHN000009905–7
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- “[GA4] Enhanced Measurement Events,” *Google*, <https://support.google.com/analytics/answer/9216061>, PBHN000009915–8
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- “Average Time on Page,” *AgencyAnalytics*, <https://agencyanalytics.com/kpi-definitions/average-time-on-page>, PBHN000009784–99
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- “Scoring Methodology: Fall 2024 Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024-1.pdf>, PBHN000009866–91
- “Scoring Methodology: Spring 2025 Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025-1.pdf>, PBHN000009808–36
- “Scoring Methodology: Spring 2025 Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025-2.pdf>, PBHN000009837–65
- “The Value of Digital Analytics,” *Google*, <https://support.google.com/analytics/answer/12159453>, PBHN000009892–3
- “What is the Average Time on Page and How to Increase It,” *Nitropack*, <https://nitropack.io/blog/post/average-time-on-page>, PBHN000009894–904

EXHIBIT C

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL CENTER,
INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

EXPERT REPORT OF PROFESSOR SEAN NICHOLSON

I, Sean Nicholson, hereby declare under penalty of perjury that the following is true and correct:

I. Introduction

1. I am a Professor in the Department of Economics and the School of Public Policy at Cornell University with an expertise in health economics. Over the past three decades, I have studied and evaluated health care quality measures, taught students how to measure health care quality, and advised hospital administrators on how to assess and improve hospital quality.

2. I have been retained by counsel for the Plaintiffs in this matter to assess i) the foundational principles that govern a proper methodology for evaluating hospital safety and quality, ii) whether the methodology that Defendant The Leapfrog Group (“TLG”) uses to develop its hospital grades conforms to these principles, and iii) the potential impact that TLG’s hospital grades may have on patient decisions regarding which hospitals to use for their medical care.

3. Based on my review of TLG’s hospital rating methodology, I find that TLG’s methodology departs from guiding principles for how hospital quality or safety should be measured, resulting in hospital grades that are misleading and unreliable predictors of actual patient outcomes, posing risks to patients, hospitals, and the public. First, TLG’s methodology generates hospital grades that are incomparable across hospitals due to non-uniform ways of

capturing various measures. Second, TLG's methodology results in unreliable and systematically biased grades that are inappropriately inflated for the hospitals that choose to participate in TLG's hospital survey and inappropriately deflated for the hundreds of hospitals that choose to not participate. In particular, I find that for each of the seven self-reported measures that focus on hospital structures and protocols, the majority of hospitals that participate in TLG's survey assign themselves the highest possible score. By contrast, for hospitals that choose not to participate in the survey (in either the current or any of the previous two rounds of the survey), TLG assigns the lowest possible score for some measures and ignores other measures altogether. As such, my analysis shows that if hospitals that chose not to participate in TLG's survey had instead participated and had responded to the survey in a manner consistent with hospitals that participated, their resulting TLG hospital grades would be substantially improved. In other words, hospitals that participate in TLG's survey are unfairly advantaged relative to those that do not. Finally, and perhaps most notably, TLG's hospital grades have been shown to be unreliable predictors of patient outcomes, with multiple studies showing that hospitals better graded by TLG fail to perform any better than lower graded hospitals with respect to important patient outcomes such as mortality and infection rates. My own analysis of data produced by TLG corroborates this finding—for a variety of patient outcome measures, I find no statistically significant difference in average patient outcomes between hospitals assigned different TLG grades.¹

¹ I understand that TLG has the opportunity to present opinions from one or more experts in this matter and that the parties are continuing to produce documents and evidence in this case. For example, I have been informed that TLG produced more than 250,000 documents in the four days before this report was due, including 93,000 documents on Sunday, August 3 and 156,000 documents on Wednesday, August 6. As I have not yet had the opportunity to meaningfully review these documents, I reserve the right to adjust my opinions based on my review of documents recently produced or that will be produced in this litigation. I also reserve the right to supplement my analysis and conclusions set forth in this report to respond to the opinions of TLG's expert(s) or based upon any additional discovery performed or disclosed by the parties.

Table of Contents

I.	Introduction.....	1
II.	Relevant Professional Background.....	4
III.	Scope of Opinions.....	8
IV.	Summary of Opinions.....	9
V.	Materials Relied Upon.....	10
VI.	Independence of Opinions and Compensation.....	11
VII.	Foundational Principles for Measuring Hospital Quality.....	11
VIII.	Hospital Ratings Influence Patient Decisions about Medical Care and Misleading Hospital Grades Can Distort Patient Choices, Causing Substantial Harm.....	15
IX.	Description of TLG’s Methodology for Evaluating Hospital Safety.....	21
X.	TLG’s Rating Methodology Is Fundamentally Flawed.....	27
A.	TLG’s Methodology for Generating Hospital Grades Fails to Provide an Appropriate Basis for Comparison of Hospitals.....	27
B.	TLG’s Rating System Results in Inappropriately Inflated Grades for Hospitals that Choose to Participate in Its Survey and Inappropriately Deflated Grades for Hospitals that Choose Not to Participate.....	30
C.	TLG’s Grades Are Not Reliable Indicators of Actual Patient Health and Safety Outcomes in Hospitals.....	41

II. Relevant Professional Background

4. I am a Professor in the Department of Economics and the School of Public Policy at Cornell University. I am also a Research Associate at the National Bureau of Economic Research. Prior to joining Cornell, I served as an Assistant Professor in Healthcare Systems at the Wharton School of the University of Pennsylvania. I have a Ph.D. in economics from the University of Wisconsin-Madison and an A.B. in economics from Dartmouth College. This section includes my relevant experience, but not my full professional background. A copy of my curriculum vitae is attached as Appendix A. A list of my testimony in the prior four years is attached as Appendix B.

5. My expertise is health economics. Over the course of my career, I have developed extensive experience in health care quality measurement and improvement through my roles as a management consultant, researcher, teacher, director of a graduate program in health administration, and hospital board member.

6. For four years at a management consulting firm called APM, I helped hospital clients reduce their expenses while maintaining or enhancing the quality of medical care they delivered to patients. I have analyzed hospital expenses, the acuity of the patient needs that hospitals treat, and the scale of teaching and research operations among comparable hospitals to establish cost reduction targets for various hospital functions such as nursing, clinical support services (e.g., radiology), administration, and purchased goods and services. I have also worked with task forces comprised of hospital staff and physicians to identify and assess operational changes that could reduce medical spending while maintaining or enhancing the quality of medical care that patients receive. Working with such task forces, I have quantified the annual cost savings associated with each proposed change and assessed whether and how the proposed change would affect patient care. For example, if a hospital proposed to decrease its ratio of registered nurses to nurse aides, I would analyze the published literature regarding the relationship between nurse staffing and patient outcomes, and I would discuss with task force members managerial actions that would ensure that patients would not be negatively affected at their hospital.

7. In my academic career, I have researched extensively the economics of the health care industry. In this field of study, I have published articles in leading academic journals and presented my research at academic conferences. Many of my peer-reviewed articles examine how to develop novel measures of the quality of medical care delivered by, or influenced by, different health care entities including physicians, hospital-based residency

programs, and health insurance plans. For instance, in 2009, I co-authored an article in the *Journal of the American Medical Association* that developed and implemented a novel method of evaluating the quality of obstetrical residency programs.² My co-authors and I found that a woman treated by an obstetrician who trained at a residency program in the top quintile based on the program's risk-standardized maternal complication rate would have a three percentage point lower probability of experiencing a complication relative to being treated by an obstetrician trained by a program in the bottom quintile of the rankings. That is, re-directing patients to higher-quality providers matters for patient outcomes.

8. In subsequent published articles, I have examined the extent to which the quality of medical care delivered by obstetricians, measured as the risk-adjusted maternal complication rate, changed in the United States between 1992 and 2006,³ and whether and how the quality of care delivered by obstetricians changes over time as they gain experience.⁴ In a 2014 article summarizing this body of research, my co-authors and I concluded that the evaluation of medical education programs should be more tightly connected to patient outcomes than the structure or process measures that have typically been used to evaluate such programs due to ease of data collection.⁵

9. In an article forthcoming in the *American Journal of Managed Care*,⁶ my co-authors and I develop a novel way of measuring the difference in the quality of medical care received by low- versus high-income people in the United States. Specifically, we calculate a summary measure for the quality of medical care received by enrollees of Medicaid Health Maintenance Organizations ("HMOs") nationally based on 39 process and outcome measures, where the former include measures such as the percentage of children who receive at least six well-child visits in their first 15 months of life and the latter include measures such as the percentage of diabetics whose blood pressure is adequately controlled. As we note in the article, our proposed summary measure for quality of medical care uses readily available, publicly reported data by health plans to the National Committee for Quality Assurance ("NCQA"). Of crucial importance for the reliability of our proposed summary measure, the data underlying

² David A. Asch et al., "Evaluating Obstetrical Residency Programs Using Patient Outcomes," *Journal of the American Medical Association* 302(12) (2009): pp. 1277–1283.

³ Sindhu K. Srinivas et al., "Improvements in US Maternal Obstetrical Outcomes From 1992 to 2006," *Medical Care* 48(5) (2010): pp. 487–493.

⁴ Andrew J. Epstein et al., "Association Between Physician Experience After Training and Maternal Obstetrical Outcomes: Cohort Study," *BMJ* 346: f1596 (2013): pp. 2–10; Andrew J. Epstein, Sean Nicholson, David A. Asch, "The Production of and Market for New Physicians' Skill," *American Journal of Health Economics* 2(1) (2016): pp. 41–65.

⁵ David A. Asch et al., "How Do You Deliver a Good Obstetrician? Outcome-Based Evaluation of Medical Education," *Academic Medicine* 89(1) (2014): pp. 24–26.

⁶ Joseph Stankaitis, Samyukta Singh, and Sean Nicholson, "Addressing Health Care Disparities Using a Health Plan Quality Measures Index," *American Journal of Managed Care* 31(9) (2025): pp. 1–19 ("Stankaitis, Singh and Nicholson (2025)").

our measure is independently audited by NCQA to ensure the data reporting is consistent across different health plans and compliant with required data specifications.

10. Similar to my research, my teaching has also been focused on the health care industry. I have received several awards for excellence in teaching such as the Weiss Presidential Fellow and SUNY Excellence in Teaching awards at Cornell University, the Helen Kardon Moss Anvil award at The Wharton School at the University of Pennsylvania, and a teaching excellence award at Worcester Academy, a high school in Massachusetts. Between 2006 and 2009 I taught a course on Health Care Information Technology and Quality Improvement to Master of Health Administration (“MHA”) graduate students at Cornell University. The three objectives of this course, as indicated in the syllabus, were (1) to understand the current state of the quality of medical care in the U.S. and salient strategies for improving quality; (2) to examine specific programs and policies for improving the quality of medical care and to analyze why they did or did not work; and (3) to evaluate how information technology can be used to measure and improve the quality of medical care and health outcomes. The course examined the different ways of defining medical care quality, how quality is measured and the challenges associated with developing accurate measures, how quality measures are used by the government and private health insurers to try to improve quality, and the impact of publicized quality measures on patients’ decisions and their health.

11. I currently teach an undergraduate course on the U.S. health care system that examines the objectives of key industry stakeholders, how they interact with one another, and salient policy issues. Each year I give two lectures on the quality of medical care in the United States, including the current state of quality, how it has changed over time, how quality is measured, why quality in the U.S. is worse than one would expect given the level of spending, policies that might improve quality, and whether those policies are working. For instance, I created an assignment that asks students to assess what they can learn about hospital quality as a prospective surgical patient, using both the New Hampshire HealthCost website and the Hospital Quality Initiative (“HQI”) website constructed by the Centers for Medicare and Medicaid Services (“CMS”). On the latter site, I ask students to identify a structure, process, and outcomes measure for two New Hampshire hospitals, compare the performance of those hospitals on those measures, and assess the utility of those measures in their hypothetical decision about where to seek treatment.

12. I also served as the Director of the Sloan Program in Health Administration at Cornell University for 10 years, between 2014 and 2024. This is a two-year graduate program

that trains students to be effective health care managers and offers a Master of Health Administration (“MHA”) degree. Although graduates work in all sectors of health care, a majority work for hospitals or health systems in operations, strategy, finance roles, or other roles. As Director, I was responsible for establishing the curriculum, setting the program’s strategy, overseeing admissions and placement, and interacting with the 1,600 alumni. To run a successful program, an MHA Director must understand what skills health care organizations are seeking and develop coursework and experiences that cultivate those skills. One skill that is highly valued is the ability of graduates to understand how to measure, monitor, and improve the quality of medical care given its critical importance for patients and the organizations that provide products and services to patients and the clinical professionals who treat patients.

13. I currently serve on the board of directors of Robert Packer Hospital in Sayre, Pennsylvania, and Atlantic Health System, a six-hospital health system based in Morristown, New Jersey. I have served on the Robert Packer board since 2009 and am also a member of their Quality Committee; I have served on the Atlantic Health System board since 2018 and am also a member of their Governance and Medical Staff Leadership and Development Committees. Atlantic Health System has a competency-based board; I was recruited because they were searching specifically for a health economist who has a national reputation.

14. A hospital or health system board such as the ones to which I belong has many responsibilities, including ensuring that the organization adheres to its mission, providing advice to senior management regarding the strategic plan and budget, recruiting senior leadership such as the chief executive officer, determining which physicians will have admitting privileges, reviewing the clinical and financial performance of the organization and offering feedback to senior management as needed, and setting the clinical, operational, and financial performance goals for the upcoming fiscal year that influence incentive compensation for senior managers.

15. Before each Quality Committee or full board meeting, board members like myself receive a packet of information highlighting the organization’s performance in the prior month relative to both the forecast and the prior year. This “dashboard” consists of dozens of medical care quality measures, most of which come from the CMS HQI or are broader applications of those measures.⁷ The Robert Packer Quality Committee dashboard, for example, includes all ten Medicare quality measures from the Hospital Consumer Assessment

⁷ “Hospital Quality Initiative,” *CMS.gov*, December 9, 2024, available at <https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative> (“CMS Hospital Quality Initiative”); “Quality Measures,” *CMS.gov*, September 10, 2024, available at <https://www.cms.gov/medicare/quality/measures>.

of Healthcare Providers and Systems (“HCAHPS”), a national, standardized, publicly reported survey of patients’ perspectives of hospital care,⁸ (e.g., percentage of patients who give the organization a five out of five for nurse communication), three Medicare hospital-acquired infection measures (e.g., percentage of patients who contracted a central line-associated bloodstream infection), eight patient throughput measures (e.g., percentage of emergency room patients who left without being seen), nine mortality measures (e.g., 30-day mortality rate for acute myocardial infarction patients), 15 readmissions-related measures (e.g., all-cause readmission for Medicare patients), and 11 patient-safety indicators (e.g., number of patients who contracted sepsis after a surgical procedure). The large number of these measures and the attention that a board devotes to them highlight the important role they play for an organization focused on providing safe and effective medical care to its patients.

III. Scope of Opinions

16. I have been retained by Gibson, Dunn & Crutcher LLP, counsel for Good Samaritan Medical Center, Inc. (“Good Samaritan”), Delray Medical Center, Inc., Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center, St. Mary’s Medical Center, Inc. (“St. Mary’s”), and West Boca Medical Center, Inc. (“West Boca”) (collectively, “Plaintiffs”). I understand that Plaintiffs have filed a Complaint against TLG, a non-profit organization that collects data from hospitals and publishes hospital grades that purport to measure hospital safety.⁹ I understand that the Complaint alleges that TLG’s methodology for issuing its Hospital Safety Grades is flawed,¹⁰ and in particular, unfairly penalizes hospitals that choose not to participate in TLG’s voluntary survey.¹¹ Plaintiffs also allege that TLG’s methodology departs from principles of accurate measurement of hospital safety and harms both health care consumers and Plaintiffs through the dissemination of deceptive and unreliable grades.¹² I have been asked by counsel for Plaintiffs to assess i) the foundational principles that govern a proper methodology for evaluating hospital safety and quality, ii) whether the methodology that TLG uses to develop its hospital grades conforms to these principles, and iii) the potential impact that TLG’s hospital grades may have on patient

⁸ See “Patient Survey Star Rating for Hospitals,” *Medicare.gov*, available at <https://www.medicare.gov/care-compare/resources/hospital/patient-survey-rating>. See also “HCAHPS: Patients’ Perspectives of Care Survey,” *CMS.gov*, September 10, 2024, available at <https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hcahps-patients-perspectives-care-survey> (“CMS HCAHPS: Patients’ Perspectives of Care Survey”).

⁹ Complaint and Demand for Jury Trial, *Good Samaritan Medical Center, Inc., Delray Medical Center, Inc., Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center, St. Mary’s Medical Center, Inc., and West Boca Medical Center, Inc. v. The Leapfrog Group*, Case No. 9:25-cv-80526, April 30, 2025 (“Complaint”).

¹⁰ Complaint, pp. 2–3.

¹¹ Complaint, pp. 3, 20–21.

¹² Complaint, pp. 49–51.

decisions regarding which hospitals to use for their medical care. I previously submitted a Declaration in this matter on May 16, 2025, as part of Plaintiffs' motion to preliminarily enjoin TLG from assigning safety grades to Plaintiffs during the pendency of the lawsuit, remove Plaintiffs from the 2025 edition of TLG's hospital grades, and permanently enjoin TLG from including Plaintiffs in its hospital grades. It is my understanding that Plaintiffs withdrew their motion for preliminary injunction when the Court set an expedited trial setting in January 2026.

IV. Summary of Opinions

17. Accurate measurement of medical care quality in general and hospital safety in particular is not only a research area for many health care economists like me, but also an important goal for many health care practitioners. It can also be a valuable informational tool for patients seeking the best medical care if the quality and safety measures reported for a given health care institution are reliable predictors of patient outcomes in that institution. For hospital ratings to be informative and able to guide patients to the appropriate hospitals, those ratings need to be based on a methodology that is applied consistently across all the different hospitals being evaluated and that does not result in ratings for some hospitals being unfairly or inappropriately inflated relative to ratings for other hospitals. Beyond consistency and lack of bias, hospital ratings are only valuable to patients if the ratings are based on measures that have been demonstrated to be predictive of actual health outcomes for hospital patients, i.e., higher rated hospitals should be shown to be associated with better patient outcomes than lower rated hospitals in order for such hospital ratings to be able to direct patients to better hospitals.

18. There is considerable empirical evidence that patients are influenced by hospital ratings in their decisions for where to seek medical care. As such, misleading hospital ratings can distort patient choices and cause harm to patients by inappropriately steering them towards hospitals that may in fact produce worse patient outcomes as compared to other hospitals, or even if no worse, may be located further away from some patients with the increased travel time itself possibly causing patient harm. Misleading hospital ratings can also cause harm to hospitals by tarnishing hospital reputation and adversely impacting critical hospital factors such as access to funds, professional standing, and recruitment of physicians and nurses. The likelihood of such harm is increased if ratings have broad patient reach and are promoted as a reliable and transparent tool for educating patients on hospital choice. This is consistent with how TLG positions its hospital grades, and yet, in reality, TLG's hospital grades are far from reliable or transparent.

19. Based on my review of TLG's hospital rating methodology, I find that TLG's methodology departs from guiding principles for how hospital quality or safety should be measured, resulting in hospital grades that are misleading and unreliable predictors of actual patient outcomes, posing risks to patients, hospitals, and the public. First, TLG's methodology generates hospital grades that are incomparable across hospitals due to non-uniform ways of capturing various measures. Second, TLG's methodology results in unreliable and systematically biased grades that are inappropriately inflated for the hospitals that choose to participate in TLG's hospital survey and inappropriately deflated for the hundreds of hospitals that choose to not participate. In particular, I find that for each of the seven self-reported measures that focus on hospital structures and protocols, the majority of hospitals that participate in TLG's survey assign themselves the highest possible score. By contrast, for hospitals that choose not to participate in the survey (in either the current or any of the previous two rounds of the survey), TLG assigns the lowest possible score for some measures and ignores other measures altogether. As such, my analysis shows that if hospitals that chose not to participate in TLG's survey had instead participated and had responded to the survey in a manner consistent with hospitals that participated, their resulting TLG hospital grades would be substantially improved. In other words, hospitals that participate in TLG's survey are unfairly advantaged relative to those that do not. Finally, and perhaps most notably, TLG's hospital grades have been shown to be unreliable predictors of patient outcomes, with multiple studies showing that hospitals better graded by TLG fail to perform any better than lower graded hospitals with respect to important patient outcomes such as mortality and infection rates. My own analysis of data produced by TLG corroborates this finding—for a variety of patient outcome measures, I find no statistically significant difference in average patient outcomes between hospitals assigned different TLG grades.

V. Materials Relied Upon

20. A list of the materials I considered in preparing this report is attached as Appendix C. Appendix D contains an additional exhibit beyond those included in the sections below. Appendix E contains workpapers that support all the calculations performed throughout this report and underlying all analyses and exhibits. My analysis in this matter is ongoing and I reserve the right to supplement or amend my opinions if I receive additional information that warrants such a supplement or amendment.

VI. Independence of Opinions and Compensation

21. I am being compensated at my standard billing rate of \$1,250 per hour. I have been assisted in this matter by staff of Cornerstone Research, who worked under my direction. I receive compensation from Cornerstone Research based on its collected staff billings for its support of me in this matter. Neither my compensation in this matter, nor my compensation from Cornerstone Research is in any way contingent or based on the content of my opinion or the outcome of this or any other matter.

VII. Foundational Principles for Measuring Hospital Quality

22. The dominant framework for determining how to define and measure the quality of medical care is one developed by Avedis Donabedian, a former University of Michigan public health professor whose 1966 research article laid the foundations for how health care researchers and practitioners have examined this topic in the decades since then.¹³ According to this framework, information about the quality of medical care can be drawn from three categories of measures: structure, process, and outcomes.¹⁴ *Outcome* measures include whether a person who has a heart attack survives or the percentage of patients who are admitted to a hospital with a heart attack and survive. Outcome measures are the “ultimate validators” of the effectiveness and quality of medical care.¹⁵ That is, health outcomes are what ultimately matter to patients and people covered by health insurance. By contrast, people do not derive any utility *directly* from structures and processes—rather, only from the outcomes that those structures and processes produce. This is one reason why the hospital quality ratings published by CMS are based on a number of outcome measures such as incidence of patients experiencing complications during a variety of hospital procedures, incidence of patients contracting infections while in the hospital, incidence of unplanned patient readmissions to the hospital, or incidence of death across different types of patients treated in the hospital.¹⁶ It is also why other hospital quality rating systems, like Healthgrades, similarly rely on data from Medicare medical claims records and data on patient outcomes produced by states (including for patients

¹³ Avedis Donabedian, “Evaluating the Quality of Medical Care,” *The Milbank Quarterly* 83(4) (2005): pp. 691–729, reprinted from *The Milbank Memorial Fund Quarterly*, 44(3) (1966): pp. 166–203 (“Donabedian (1966)”). See also Donald Berwick and Daniel M. Fox, “Evaluating the Quality of Medical Care: Donabedian’s Classic Article 50 Years Later,” *The Milbank Quarterly* 94(2) (2016): pp. 237–241.

¹⁴ Donabedian (1966), pp. 692–695.

¹⁵ Donabedian (1966), p. 694.

¹⁶ “Measures and Current Data Collection Periods,” *CMS.gov*, available at <https://data.cms.gov/provider-data/topics/hospitals/measures-and-current-data-collection-periods> (“CMS Measures and Current Data Collection Periods”).

whose hospital visits were covered by other payors apart from Medicare) to determine patients' actual clinical outcomes when visiting a given hospital.¹⁷

23. In addition, accurate outcome measures should be risk-adjusted to account for differences in initial illness severity and factors outside of the health care system, which impact the likelihood of positive health outcomes. For example, some patients who experience a heart attack are relatively old and also have diabetes and congestive heart failure, and thus are less likely to survive relative to a healthier person even if they receive very high quality, evidence-based medical care. Similarly, some patients may choose to follow discharge instructions while others may not, which could also impact health outcomes regardless of the quality of medical care delivered. Therefore, it is important to measure also the *processes* of medical care—i.e., whether the services delivered to a patient adhere to evidence-based medicine based on the health condition or conditions the patient has—in addition to patients' health outcomes.¹⁸

24. Finally, there are some *structures* (e.g., whether a hospital has implemented an electronic medical record system, or whether a physician is board certified in a specialty) that increase the likelihood that providers will use recommended medical services that produce, on average, superior health outcomes.¹⁹ Thus, although outcomes are what really matter, measuring processes and structures that facilitate and predict good outcomes is also productive and complementary to measuring risk-adjusted outcomes. The ideal medical quality measurement method for hospitals would focus on health outcomes that are important to prospective hospital patients, along with process and structure measures that are predictive of those outcomes.

25. Quality measurements should be collected and reported in an accurate, standardized, and consistent manner across all organizations being evaluated. This instills confidence that the data are valid and ensures integrity and fairness to all organizations being evaluated. That is, a reliable rating system is one that is based on apples-to-apples comparisons across the organizations. This is especially important because ratings are often determined by an organization's position in the national distribution. If one organization is allowed to define or interpret a measure differently than others in a way that overstates their performance, that organization will "move up" the distribution inappropriately and simultaneously "push" many other organizations down the distribution. If patients make decisions based on ratings that use

¹⁷ "Hospital Ratings & Awards Methodologies," *Healthgrades*, available at <https://www.healthgrades.com/quality/ratings-awards/methodology>.

¹⁸ Donabedian (1966), p. 694.

¹⁹ Donabedian (1966), p. 695.

such a measure or if payers tie financial incentives to this measure, patients and money will be reallocated between health care organizations based on the lack of standardization across organizations in how the data were reported.

26. There are several best practices for ensuring that the quality measures, and the ratings that are generated from those measures, are accurate, standardized, and consistent.²⁰ Each quality measure should be clearly defined so that it is objective and does not rely on organizations making judgement calls. For example, an all-cause acute myocardial infarction (“AMI”) readmission—an often-used measure of medical care quality—is defined as a subsequent hospital admission that occurs within 30 days of a patient’s initial AMI admission and where this subsequent admission is not for a previously planned, or staged procedure (e.g., performing an angioplasty on a different blood vessel than was treated during the initial admission).²¹

27. If some subjectivity in a measure is inevitable, ideally a rubric would be provided so that organizations score themselves using the same metrics.²² For example, Medicare penalizes physicians if they do not demonstrate “meaningful use” of an electronic health records (“EHR”) system.²³ Although CMS allows each physician to attest whether or not they are demonstrating meaningful use of EHR, CMS defines the eight objectives that collectively determine meaningful use.²⁴

28. Health care quality ratings or measures are often based on where an organization’s performance is in the national, all-organization, performance distribution in terms of its percentile (e.g., top-quartile, bottom-quartile).²⁵ Therefore, collecting a quality measure from *all* health care organizations is an important way to ensure accuracy, standardization, and consistency. If some organizations do not provide a specific quality

²⁰ For example, as part of the HCAHPS program, CMS conducts “quality oversight activities, including inspection of survey administration procedures, statistical analyses of submitted data, and site visits of HCAHPS survey vendors and self-administering hospitals, to assure that the HCAHPS survey is being administered according to the protocols.” Similarly, the NCQA data submitted by health plans that I have used in my research to measure health plan quality is independently audited by NCQA. See CMS HCAHPS: Patients’ Perspectives of Care Survey; Stankaitis, Singh and Nicholson (2025).

²¹ “2024 Condition-Specific Readmission Measures Updates and Specifications Report,” Yale New Haven Health Services Corporation — Center for Outcomes Research and Evaluation, April 2024, available at https://qualitynet.cms.gov/files/663548ea2b87360fd3523eff?filename=2024_CSR_AUS_Report_v1.0.pdf, pp. 9, 76–77.

²² Donabedian (1966). See also “Using Rubrics,” *Cornell University Center for Teaching Innovation*, available at <https://teaching.cornell.edu/teaching-resources/assessing-student-learning/using-rubrics>.

²³ “Meaningful Use: Electronic Health Record (EHR) incentive programs,” *American Medical Association*, available at <https://www.ama-assn.org/practice-management/medicare-medicare/meaningful-use-electronic-health-record-ehr-incentive>.

²⁴ Reda Chouffani, “Meaningful Use Stage 3,” *TechTarget*, September 2016, available at <https://www.techtarget.com/searchhealthit/definition/meaningful-use-stage-3>.

²⁵ For example, the CMS Five-Star Quality Rating System for Hospitals “evaluates the overall performance of hospitals in the USA and assigns a rating to hospitals ... [based on] how well that hospital performed as compared with other hospitals in the USA.” Nisha Kurian et al., “Predicting Hospital Overall Quality Star Ratings in the USA,” *Healthcare* 9(4) (2021): pp. 1–12, p. 1.

measure, information on the national distribution is incomplete, which creates statistical challenges. Omitting data from the non-reporting organizations can bias ratings for the organizations that do report because their positions in the observed, truncated distribution may differ from their positions with complete reporting. Furthermore, imputing values for the non-reporting organizations can also bias ratings if the statistical method does not accurately predict the non-reported values.

29. The best way to avoid these statistical challenges is to collect quality measures from all health care organizations so the full national distribution is observed. For example, Medicare mandates that all hospitals provide data to the CMS HQR, and thus avoids a need for imputation of missing data. Alternatively, if the financial incentives to report voluntarily are sufficiently strong, organizations are likely to report.²⁶ For example, the Joint Commission on Accreditation of Healthcare Organizations (“Joint Commission”) is a national body that accredits and evaluates more than 23,000 health care organizations including hospitals in the U.S.²⁷ In order to be accredited by the Joint Commission and maintain this accreditation, health care organizations must undergo on-site evaluations by a Joint Commission survey team at least every three years.²⁸ The survey team consists of trained experts who are doctors, nurses, hospital administrators, and other health care professionals. During the on-site evaluation, the expert team selects a random sample of patients at each hospital, examines their medical records to evaluate compliance with medical standards, interviews and conducts observations of hospital staff, and speaks to the patients themselves.²⁹ Although accreditation by the Joint Commission is voluntary, if a hospital meets accreditation standards, that makes the hospital eligible to receive federal reimbursement from CMS.³⁰ Many states also include accreditation by the Joint Commission among their hospital licensing requirements.³¹ As a result, many

²⁶ CMS value-based programs require mandatory reporting and penalizes hospitals that fail to report with reduced payments and penalties. “Audits and Penalties,” *CMS.gov*, September 10, 2024, available at <https://www.cms.gov/OpenPayments/Program-Participants/Reporting-Entities/Audits-and-Penalties> (“CMS Audits and Penalties”); “What Are Value-Based Programs?” *CMS.gov*, September 25, 2024, available at <https://www.cms.gov/medicare/quality/value-based-programs>. See also “CMS Inpatient Value, Incentives, and Quality Reporting Programs Overview,” *Quality Reporting Center*, December 2020, available at https://www.qualityreportingcenter.com/globalassets/2021/06/cms-ivqr-programs-overview_fy-2023_vfinal508.pdf.

²⁷ “History of the Joint Commission,” *The Joint Commission*, available at <https://www.jointcommission.org/who-we-are/facts-about-the-joint-commission/history-of-the-joint-commission/> (“History of the Joint Commission”).

²⁸ History of the Joint Commission.

²⁹ “Joint Commission FAQs,” *The Joint Commission*, available at <https://www.jointcommission.org/who-we-are/facts-about-the-joint-commission/joint-commission-faqs/>.

³⁰ “Federal Deemed Status Fact Sheet,” *The Joint Commission*, available at <https://www.jointcommission.org/resources/news-and-multimedia/fact-sheets/facts-about-federal-deemed-status/> (“Joint Commission Federal Deemed Status”). See also Sarah A. Ibrahim et al., “The Evidence Base for US Joint Commission Hospital Accreditation Standards: Cross Sectional Study,” *BMJ* 377:e063064 (2022) (“Ibrahim et al. (2022)”), p. 1.

³¹ Joint Commission Federal Deemed Status; Ibrahim et al. (2022), p. 1.

hospitals seek accreditation by the Joint Commission,³² and in my experience as a hospital board member, maintaining accreditation by the Joint Commission is a very valuable signal of hospital quality.³³

30. Another way to promote accuracy, consistency, and standardization is to allow the entity collecting data to audit the submitting organizations in order to ensure the data have been submitted appropriately. Organizations may be fined based on the results of an audit. CMS follows such a policy with hospital Medicare reimbursement.³⁴ When Medicare bases incentive payments on quality that is measured in claims data, Medicare performs the initial calculations itself, sends a report to each hospital, and then allows each hospital to submit questions regarding the calculations and to request corrections.

VIII. Hospital Ratings Influence Patient Decisions about Medical Care and Misleading Hospital Grades Can Distort Patient Choices, Causing Substantial Harm

31. As discussed above in Section VII, when evaluating hospital safety, it is important for the measures to be accurate, consistently recorded across different hospitals, and good predictors of actual patient outcomes. Otherwise, one cannot obtain an accurate

³² “Hospital Accreditation Fact Sheet,” *The Joint Commission*, available at <https://www.jointcommission.org/resources/news-and-multimedia/fact-sheets/facts-about-hospital-accreditation/>.

³³ I understand that Plaintiffs have received accreditations from the Joint Commission, as well as a number of other accreditations and certifications, which required a peer-reviewed accreditation process. Plaintiff Palm Beach Gardens Medical Center’s Responses and Objections to Defendant The Leapfrog Group’s First Set of Interrogatories to Palm Beach Gardens Medical Center, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, Case No. 9:25-CV-80526-DMM, July 25, 2025 (“Palm Beach Response to First Set of Interrogatories (July 25, 2025)”), No. 13, pp. 13-14; Declaration of Erik Cazares, May 13, 2025 (“Cazares Declaration”), ¶ 10 (PBHN000002167); Plaintiff Delray Medical Center, Inc.’s Responses and Objections to Defendant The Leapfrog Group’s First Set of Interrogatories to Delray Medical Center, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, Case No. 9:25-CV-80526-DMM, July 25, 2025 (“Delray Response to First Set of Interrogatories (July 25, 2025)”), No. 12, p. 14; Declaration of Heather Havericak, May 14, 2025 (“Havericak Declaration”), ¶ 9 (PBHN000002114); Plaintiff Good Samaritan Medical Center, Inc.’s Responses and Objections to Defendant The Leapfrog Group’s First Set of Interrogatories to Good Samaritan Medical Center, Inc., *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, Case No. 9:25-CV-80526-DMM, July 25, 2025 (“Good Samaritan Response to First Set of Interrogatories (July 25, 2025)”), No. 12, pp. 13-14; Declaration of Sheri Montgomery, May 14, 2025 (“Montgomery Declaration”), ¶ 10 (PBHN000002140); Plaintiff St. Mary’s Medical Center, Inc.’s Responses and Objections to Defendant The Leapfrog Group’s First Set of Interrogatories to St. Mary’s Medical Center, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, Case No. 9:25-CV-80526-DMM, July 25, 2025 (“St. Mary’s Response to First Set of Interrogatories (July 25, 2025)”), No. 12, pp. 13-15; Declaration of Cynthia McCauley, May 13, 2025 (“McCauley Declaration”), ¶ 11 (PBHN000002219); Plaintiff West Boca Medical Center, Inc.’s Responses and Objections to Defendant The Leapfrog Group’s First Set of Interrogatories to West Boca Medical Center, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, Case No. 9:25-CV-80526-DMM, July 25, 2025 (“West Boca Response to First Set of Interrogatories (July 25, 2025)”), No. 12, pp. 13-14; Declaration of Jerad Hanlon, May 13, 2025 (“Hanlon Declaration”), ¶ 9 (PBHN000002194).

³⁴ CMS Audits and Penalties. CMS can similarly reduce hospital Medicare reimbursement through payment adjustment programs (e.g., Hospital Value-Based Purchasing (“VBP”) Program, Hospital-Acquired Condition Reduction Program (HACRP), and Hospital Readmissions Reduction Program (“HRRP”)) and retains the right to audit data relevant to these programs. See Section 1886(b)(3)(B)(viii)(XI) of the Social Security Act. See also “Hospital Value-Based Purchasing Program,” *CMS.gov*, September 10, 2024, available at <https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hospital-value-based-purchasing>; “Hospital-Acquired Condition Reduction Program,” *CMS.gov*, September 10, 2024, available at <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-acquired-condition-reduction-program-hacrp>; “Hospital Readmissions Reduction Program (HRRP),” *CMS.gov*, September 10, 2024, available at <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-readmissions-reduction-program-hrrp>.

understanding of the patient safety levels offered by a given hospital or evaluate that safety accurately relative to the safety levels offered by other hospitals.

32. The health economics literature has demonstrated that patients pay attention to hospital ratings and these ratings affect where patients seek medical care. For example, a 2004 study examined how patients are impacted by publicly available hospital ratings based on the New York State Cardiac Surgery Reporting System, a system that evaluated and reported risk-adjusted mortality rates in New York hospitals for patients who received coronary artery bypass graft surgery.³⁵ The study showed that hospitals that are publicly identified and flagged by this system as being of low quality (e.g., performing significantly below the state average) experience a significant loss in patient volume during the first 12 months after the hospital ratings come out.³⁶ Similarly, a 2009 study examined the impact of hospital ratings from the *U.S. News and World Report* on patient volume and hospital revenue.³⁷ The study found that an improvement in a hospital's publicly available rating within a given specialty led to a significant increase in the number of patients who sought care from and were treated by physicians within that hospital specialty.³⁸ More recently, a 2016 study demonstrated that hospitals that score higher on quality measures publicly reported by CMS experience higher growth in patient volume (measured relative to patient volume in other hospitals) following the public release of the CMS hospital quality measures.³⁹ Additionally, the study found that this effect is stronger for hospital admissions where patients have a greater say over the hospital choice (i.e., cases where patients are not brought to the hospital emergency room via an ambulance).⁴⁰ The study authors interpret this as additional evidence that publicly reported data on hospital quality can have a substantial effect on patient preferences over hospitals and patient demand for one hospital over another.⁴¹

33. In addition to this general evidence that patients make hospital choices based on publicly available information regarding relative hospital quality, there is evidence that TLG promotes its hospital safety grades as a reliable tool for patients to use in choosing their hospitals. For example, TLG positions itself as the “nation’s leading independent advocate of

³⁵ David M. Cutler et al., “The Role of Information in Medical Markets: An Analysis of Publicly Reported Outcomes in Cardiac Surgery,” *American Economic Review* 94(2) (2004): pp. 342–346 (“Cutler et al. (2004)”).

³⁶ Cutler et al. (2004), p. 344.

³⁷ Devin G. Pope, “Reacting to Rankings: Evidence from ‘America’s Best Hospitals,’” *Journal of Health Economics* 28 (2009): pp. 1154–1165 (“Pope (2009)”).

³⁸ Pope (2009), pp. 1160–1161, 1163.

³⁹ Amitabh Chandra et al., “Health Care Exceptionalism? Performance and Allocation in the US Health Care Sector,” *American Economic Review* 106(8) (2016): pp. 2110–2144 (“Chandra et al. (2016)”), pp. 2110–2111, 2122, 2139–2140.

⁴⁰ Chandra et al. (2016), see abstract.

⁴¹ Chandra et al. (2016), pp. 2139–2140.

health care transparency,”⁴² and repeatedly emphasizes the reliability of its hospital data in external communications to potential data users. In describing its safety grades on its website, TLG states that “the Leapfrog Hospital Survey is the nation’s gold standard in evaluating hospital performance.”⁴³ TLG also indicates that its hospital survey meets “rigorous standards” and that it holds the data “to the highest standards of validity and reliability.”⁴⁴ Notably, TLG states that its hospital safety grades are widely used by a variety of health care organizations such as health plans, employers, and transparency vendors to “educate” patients on hospital performance and “aid” them in “choosing a hospital.”⁴⁵ TLG emphasizes the importance of its grades in informing patients’ hospital choice by claiming that hospitals receiving poor grades of “D” or “F” from TLG “carry nearly twice the risk of mortality as A hospitals” and that “[o]ver 50,000 lives could be saved every year if all hospitals performed at the level of [TLG’s] A graded hospitals.”⁴⁶ The basis for these claims appears to be a 2019 white paper (“TLG white paper”) that was “[p]repared for The Leapfrog Group.”⁴⁷ This white paper, which is neither peer-reviewed nor published in an academic journal, purports to estimate the “number of avoidable deaths in hospitals [that received from TLG] each letter grade (‘A’ vs. ‘B’ vs. ‘C’ vs. ‘D, F’),”⁴⁸ and concludes that “[i]f hospitals with a grade lower than an ‘A’ are able to achieve the safety performance of ‘A’ hospitals...more than 50,000 patient lives could be saved.”⁴⁹ In other words, the authors of the TLG white paper make a *causal* claim about the impact of achieving a safety grade of “A” on patient mortality. However, the analysis in the TLG white paper is inadequate to establish any such causal relationship.⁵⁰ Further, the TLG

⁴² “Frequently Asked Questions About the Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, May 1, 2025, available at <https://www.hospitalsafetygrade.org/frequently-asked-questions> (“FAQ About TLG Hospital Safety Grade”).

⁴³ “Our Ratings,” *The Leapfrog Group*, available at <https://ratings.leapfroggroup.org/our-ratings>.

⁴⁴ “Health Care Ratings and Reports,” *The Leapfrog Group*, available at <https://www.leapfroggroup.org/ratings-reports>.

⁴⁵ “Types of Data Users,” *The Leapfrog Group*, available at <https://www.leapfroggroup.org/data-users/types-data-users>.

⁴⁶ “Lives Lost and Lives Saved,” *The Leapfrog Group*, available at <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/LivesLost>.

⁴⁷ Matt Austin and Jordan Derk, “Lives Lost, Lives Saved: An Updated Comparative Analysis of Avoidable Deaths at Hospitals Graded by The Leapfrog Group,” *Armstrong Institute for Patient Safety and Quality Johns Hopkins Medicine* (2019) (“TLG white paper”).

⁴⁸ TLG white paper, p. 2.

⁴⁹ TLG white paper, p. 6.

⁵⁰ A proper causal analysis involves carefully isolating the impact, if any, of a variable of interest (e.g., the TLG hospital grade) on an outcome of interest (e.g., patient mortality), controlling for other variables that may impact the outcome of interest. The TLG white paper performs no such analysis to arrive at its causal conclusion. Unobserved confounding factors that affect both the TLG grades and the outcome measures could bias the purported observed relationship between TLG grades and outcome measures. For example, hospitals that have greater resources may receive higher TLG grades and also achieve better patient outcomes, but if this factor of resource availability is not accounted for, one may erroneously attribute better patient outcomes to TLG grades rather than resource availability. See, e.g., Jeffrey M. Wooldridge, *Introductory Econometrics*, 5e, (Mason, OH: South-Western, Cengage Learning, 2013), p. 12 (“In most tests of economic theory, and certainly for evaluating public policy, the economist’s goal is to infer that one variable (such as education) has a causal effect on another variable (such as worker productivity). Simply finding an association between two or more variables might be suggestive, but unless causality can be established, it is rarely compelling.”), p. 88 (“suppose that, rather than including an irrelevant variable, we omit a variable that actually belongs in the true (or population) model. This is often called the problem of excluding a relevant variable or underspecifying the model.”).

white paper uses the same fundamentally flawed data inputs that TLG uses to derive its grades (and that I describe in greater detail in Sections IX and X), thereby rendering both the TLG white paper's analysis and TLG's claims based on this analysis as misleading as TLG's grades themselves.⁵¹ Notably, TLG still reiterates the 2019 white paper's *causal* claim even though that claim is even more misleading today given the methodological change TLG implemented in Fall 2024 that, as described in greater detail in Sections IX and X, further increased the disadvantage to hospitals that do not respond to TLG's survey.

34. Given TLG's promotion of its hospital grades as a reliable and transparent tool for educating patients, as well as TLG's own assessment of the broad patient reach of its grades, TLG's hospital grades can have a significant impact on which hospitals patients choose.⁵² This impact, however, can be harmful rather than beneficial to patient health, given that as discussed below in Section X, TLG's hospital grades provide misleading information about actual hospital quality. Indeed, as noted in Section X below, a hospital graded higher by TLG may be

⁵¹ The TLG white paper's methodology results in systematic bias by using different data sources for participating versus non-participating hospitals. As I explain in Sections X.A and X.B, these different sources sometimes contain data that do not match. For example, the National Healthcare Safety Network, one of the data sources used for participating hospitals, allows hospitals to change their data retroactively while CMS, the alternative data source used for non-participating hospitals, does not. In other words, participating hospitals are permitted to retroactively adjust their data, but non-participating hospitals are not provided this same opportunity. See "Leapfrog Hospital Safety Grade Scoring Methodology," *The Leapfrog Group*, April 21, 2025, available at <https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025-1.pdf> ("Spring 2025 TLG Scoring Methodology"), p. 13; NHSN Guidance: Join the Group, Data Rights Template, and Downloading Reports," *The Leapfrog Group*, July 9, 2025, available at https://www.leapfroggroup.org/sites/default/files/Files/2025_NHSN_Instructions_v04.pdf ("NHSN Guidance (2025)"), pp. 19–20. As another example, at the time the white paper was written, TLG used data from a survey administered by the American Hospital Association for non-participating hospitals even though this survey had a lower maximum possible score than TLG's survey. TLG's methodology did not take into account the different point scales for the two surveys, which resulted in non-participating hospitals having their scores appear inappropriately deflated relative to the scores of participating hospitals. As I explain further in Section X.B and as documented in academic literature, participating hospitals are more likely to appear to do better on certain outcomes and more likely to be higher graded than non-participating hospitals. This creates an artificial difference in outcomes between higher graded and lower graded hospitals which the TLG white paper and TLG itself inappropriately attribute to higher grades leading to "lives saved." See TLG white paper, Table A.

⁵² I understand that Plaintiffs have received reports from patients who have made hospital choices based on the hospital grades assigned by TLG. Palm Beach Response to First Set of Interrogatories (July 25, 2025), No. 23, p. 21; Cazares Declaration, ¶ 24 (PBHN000002167); Delray Response to First Set of Interrogatories (July 25, 2025), No. 22, p. 21; Haverick Declaration, ¶¶ 26, 28 (PBHN000002114); Good Samaritan Response to First Set of Interrogatories (July 25, 2025), No. 22, p. 21; PBHN000002076; Montgomery Declaration, ¶¶ 27–28 (PBHN000002140); St. Mary's Response to First Set of Interrogatories (July 25, 2025), No. 22, p. 22; McCauley Declaration, ¶ 37 (PBHN000002219); Hanlon Declaration, ¶¶ 23–25 (PBHN000002194); West Boca Response to First Set of Interrogatories (July 25, 2025), No. 22, p. 21. TLG promotes its Hospital Safety Grades and publicly encourages patients to rely on them when choosing a hospital. See, e.g., "Choosing the Best Hospital," *Leapfrog Hospital Safety Grade*, available at <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/choosing-the-best-hospital> ("Your choice of hospital could be a life or death decision... Your first step in finding the best care for yourself and your family is finding a safer hospital. Use the Leapfrog Hospital Safety Grade search tool to find the safest hospital in your area, preferably one with an 'A' grade."); "How to Use the Grade," *Leapfrog Hospital Safety Grade*, available at <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/how-to-use-the-grade> ("[N]o matter the reason for a hospital visit, safety should be your number one concern... Patients should always decide on where to receive care based on a hospital's current Safety Grade. However, past grades can tell you a lot about that hospital's track record in keeping its patients safe from errors, injuries, accidents and infections."); The Leapfrog Group, "Leapfrog's Spring 2025 Safety Grades Are In — New Trend Data Shows One in Eight Hospitals Sustained an 'A' for More Than Two Years," May 1, 2025, available at <https://www.leapfroggroup.org/news-events/leapfrog%E2%80%99s-spring-2025-safety-grades-are-%E2%80%94-new-trend-data-shows-one-eight-hospitals> ("[T]here's still significant variation in safety across U.S. hospitals," [president and CEO of The Leapfrog Group, Leah] Binder added. "That's why it's so important for people to consult Safety Grades when making decisions about seeking care. All hospitals are not the same.""). See also Expert Report of Jonah Berger, Ph.D., August 7, 2025, Sections V and VI.

no better or in fact may be worse in terms of patient infections, readmissions, or mortality rates than a hospital graded lower by TLG.

35. That TLG's inaccurate and misleading hospital grades can harm rather than improve patient health can be also illustrated by the following. For each of the zip codes where three of the five Plaintiffs are located (except Good Samaritan and St. Mary's), Plaintiffs are the only hospitals within five miles of the respective zip code, and each of these Plaintiffs has received a TLG grade of "F."⁵³ For the zip codes within which Good Samaritan and St. Mary's are located, there is only one hospital with a higher grade by TLG—a grade of "C."⁵⁴ To the extent that these poor grades by TLG lead some patients who live in these zip codes to travel further to reach a hospital that received a better grade from TLG, such action may be not only unnecessary—given the potentially misleading nature of these grades—but actually harmful to patient health. Indeed, a 2014 study that analyzed the relationship between distance to a health care facility and health outcomes for scheduled surgeries showed that patients have worse health outcomes as the distance to their chosen health care facilities increases.⁵⁵ More specifically, another study found that longer travel distance to hospitals during medical emergencies is associated with an increase in patient mortality.⁵⁶

36. I understand that some state laws recognize the potential negative impact of travel distance on patient outcomes. For example, Florida state law requires that "all medically necessary transfers shall be made to the geographically closest hospital with the service capability."⁵⁷ Further, guidelines set forth by the American College of Emergency Physicians

⁵³ These grades are the last available grades released by TLG in Spring 2025. "How Safe is Your Hospital: Hospital Matches – Within 5 miles from the Center of 33484," *Leapfrog Hospital Safety Grade*, available at https://www.hospitalsafetygrade.org/search?findBy=zip&zip_code=33484&radius=5&city=&state_prov=&hospital=; "How Safe is Your Hospital: Hospital Matches – Within 5 miles from the Center of 33410," *Leapfrog Hospital Safety Grade*, available at

https://www.hospitalsafetygrade.org/search?findBy=zip&zip_code=33410&radius=5&city=&state_prov=&hospital=; "How Safe is Your Hospital: Hospital Matches – Within 5 miles from the Center of 33428," *Leapfrog Hospital Safety Grade*, available at

https://www.hospitalsafetygrade.org/search?findBy=zip&zip_code=33428&radius=5&city=&state_prov=&hospital=.
⁵⁴ "How Safe is Your Hospital: Hospital Matches – Within 5 miles from the Center of 33401," *Leapfrog Hospital Safety Grade*, available at

https://www.hospitalsafetygrade.org/search?findBy=zip&zip_code=33401&radius=5&city=&state_prov=&hospital=; "How Safe is Your Hospital: Hospital Matches – Within 5 miles from the Center of 33407," *Leapfrog Hospital Safety Grade*, available at

https://www.hospitalsafetygrade.org/search?findBy=zip&zip_code=33407&radius=5&city=&state_prov=&hospital=.

⁵⁵ ShinYi Chou, Mary E. Deily and Sihui Li, "Travel Distance and Health Outcomes for Scheduled Surgery," *Medical Care* 52(3) (2014): pp. 250–257, p. 250. Additionally, a 2016 study conducting a systematic review of literature found that patients have worse health outcomes as distance to health care facilities increased. See Charlotte Kelly et al., "Are Differences in Travel Time or Distance to Healthcare for Adults in Global North Countries Associated with an Impact on Health Outcomes? A Systematic Review," *BMJ Open* (2016), p. 1.

⁵⁶ Thomas C. Buchmueller, Mireille Jacobson and Cheryl Wold, "How Far To The Hospital?: The Effect Of Hospital Closures on Access to Care," *Journal of Health Economics* 25(4) (2006): pp. 740–761, p. 740. See also Jon Nicholl et al., "The Relationship Between Distance to Hospital and Patient Mortality in Emergencies: An Observational Study," *Emergency Medicine Journal* 24 (2007): pp. 665–668, p. 665.

⁵⁷ Fl. Code 395.1041(4)(e).

(“ACEP”) state that for emergency care in a pre-hospital setting, patients should be transported to the nearest appropriate emergency department, in accordance with applicable laws, regulations, and guidelines.⁵⁸ These state laws and physician guidelines, however, only apply to patients who are transported with ambulances; for patients who transport themselves or transport family members to hospitals, the choice of hospital is up to the patients or their families.⁵⁹

37. Given the evidence that patients rely on hospital ratings to inform their hospital choices, accurate hospital ratings can improve patient welfare by steering patients towards better hospitals. Conversely, inaccurate and misleading hospital ratings, like those put forth by TLG, as I will discuss below, can distort patient choices and decrease patient welfare. These ratings can be harmful to patients by inappropriately steering them to hospitals that are in fact worse than others, or even if no worse, to hospitals that take longer to reach with the increased travel itself being potentially harmful to patients.⁶⁰

38. In view of the extent to which hospital ratings can affect patients’ hospital choices, misleading hospital ratings can cause harm to a hospital’s reputation. Academic literature has found that such public reports on hospital quality “can affect the public image or reputation of a provider or medical care organization”⁶¹ and that a “downturn in reputation” can adversely impact critical factors such as a hospital’s ability to raise funds (as charitable donations are an important source of income for not-for-profit hospitals),⁶² “maintain legitimacy and professional standing,”⁶³ and “recruit[sic] and retain[sic] qualified physicians and nurses.”⁶⁴ Indeed, I understand that chief executive officers of Plaintiff hospitals have noted that their hospitals have suffered substantial reputational harm as a result of the poor grades they were assigned by TLG, and that reputational harm has been accompanied by a decline in

⁵⁸ “Emergency Department Planning and Resource Guidelines,” *Annals of Emergency Medicine* 51(5) (2008): pp. 687–695 (“Emergency Department Planning and Resource Guidelines (2008)”), p. 693.

⁵⁹ Emergency Department Planning and Resource Guidelines (2008); “Emergency Ambulance Destination,” *Annals of Emergency Medicine* 34(1) (1999).

⁶⁰ Although TLG acknowledges the risk to patients of refusing emergency medical care, it still encourages patients to use its Hospital Safety Grades as a “research tool for potential emergencies.” See “How to Use the Grade,” *Leapfrog Hospital Safety Grade*, available at <https://www.hospitalsafetygrade.org/how-to-use-the-grade> (“You should never refuse care in an emergency because of a hospital’s Safety Grade, but use this website as a guide for planned events and a research tool for potential emergencies.”).

⁶¹ Judith H. Hibbard, Jean Stockard, and Martin Tusler, “Hospital Performance Reports: Impact on Quality, Market Share, And Reputation,” *Health Affairs* 24(4) (2005): pp. 1150–1160 (“Hibbard et al. (2005)”), p. 1151.

⁶² Hibbard et al. (2005), p. 1159.

⁶³ Hibbard et al. (2005), p. 1151.

⁶⁴ Hibbard et al. (2005), p. 1151.

total outpatient visits, referred outpatient visits, and outpatient surgeries, as well as recruitment challenges and worsened relationships with physicians.⁶⁵

IX. Description of TLG's Methodology for Evaluating Hospital Safety

39. TLG is a non-profit organization that has conducted annual surveys of hospital quality and safety since 2001 and has published "Hospital Safety Grades" since 2012.⁶⁶ More specifically, TLG publishes letter grades ("A" through "F") biannually for nearly 3,000 general acute care hospitals across the country.⁶⁷ The stated purpose of TLG's Hospital Safety Grades is to "educate consumers and purchasers about the safety and quality of healthcare facilities in their community so they can choose the best place for their care."⁶⁸

40. TLG's Hospital Safety Grades aggregate a variety of patient safety measures to produce a single letter grade that purports to represent a hospital's overall performance in keeping patients safe from preventable harm and medical errors.⁶⁹ The measures that comprise each Hospital Safety Grade come from the survey responses hospitals provide to TLG, CMS data, and other supplemental sources.⁷⁰ These data sources produce up to 22 patient safety measures that are then aggregated into each Hospital Safety Grade.⁷¹ TLG's hospital survey is a substantial undertaking: The most recent survey is 353 pages long, and its length has increased over time.⁷²

⁶⁵ Palm Beach Response to First Set of Interrogatories (July 25, 2025), No. 23, p. 21; Cazares Declaration, ¶¶ 24–26 (PBHN000002167); West Boca Response to First Set of Interrogatories (July 25, 2025), No. 22, p. 21; Hanlon Declaration, ¶¶ 23–25 (PBHN000002194); PBHN000002103; Delray Response to First Set of Interrogatories (July 25, 2025), No. 22, p. 21; Havericak Declaration, ¶¶ 24–28 (PBHN000002114); PBHN000002071; McCauley Declaration, ¶¶ 36–37 (PBHN000002219); Good Samaritan Response to First Set of Interrogatories (July 25, 2025), No. 22, p. 21; PBHN000002076; PBHN000002090; PBHN000002095; St. Mary's Response to First Set of Interrogatories (July 25, 2025), No. 22, p. 22; Montgomery Declaration, ¶¶ 25–28 (PBHN000002140).

⁶⁶ "History," *The Leapfrog Group*, available at <https://www.leapfroggroup.org/about/history>.

⁶⁷ Due to limited availability of public data, TLG does not calculate Hospital Safety Grades for the following types of hospitals: Critical access hospitals ("CAH"), rural emergency hospitals ("REH"), long-term care and rehabilitation facilities, mental health facilities, federal hospitals (e.g., Veterans Affairs, Indian Health Services, etc.), some specialty hospitals, such as surgery centers and cancer hospitals, free-standing pediatric hospitals, hospitals in U.S. territories, and hospitals that are missing scores for more than six process/structural measures, or more than five outcome measures, or missing Patient Safety Indicator ("PSI") 90. Spring 2025 TLG Scoring Methodology, p. 3.

⁶⁸ "How Our Ratings Are Used," *The Leapfrog Group*, available at <https://www.leapfroggroup.org/ratings-reports/how-our-ratings-are-used> ("TLG How Our Ratings Are Used"); "Who We Are," *The Leapfrog Group*, available at <https://www.leapfroggroup.org/about>.

⁶⁹ Spring 2025 TLG Scoring Methodology, p. 3.

⁷⁰ Spring 2025 TLG Scoring Methodology, p. 3.

⁷¹ A hospital may not have a score for all 22 measures due to missing data. Spring 2025 TLG Scoring Methodology, pp. 3–4.

⁷² See "Leapfrog Hospital Survey Hard Copy," *The Leapfrog Group*, May 2, 2025, available at https://www.leapfroggroup.org/sites/default/files/Files/2025%20HospitalSurvey_20250502_v9.1%20%28version%20%29.pdf. A 2024 academic study conducted a field experiment to understand the time commitment involved in completing TLG's survey. The authors noted that at the beginning of 2023, TLG's "survey size was overwhelming (317 pages)," and for a first-time participating hospital, the process involved "12 people dedicat[ing] 117 hours which was in addition to the project

41. For hospitals that choose to participate in TLG's hospital survey ("participating hospitals"), TLG uses the hospitals' self-reported survey responses for the majority of its measures, i.e., for 12 of the 22 measures.⁷³ For measures not recorded on a continuous scale, TLG uses hospitals' survey responses and places them in one of five performance categories:⁷⁴

1. "Achieved the Standard"
2. "Considerable Achievement"
3. "Some Achievement"
4. "Limited Achievement"
5. "Unable to Calculate Score" or "Does Not Apply."

42. However, many hospitals choose not to participate in TLG's hospital survey ("non-participating hospitals"). In 2013, more than half of hospitals scored by TLG did not participate in its survey.⁷⁵ Although the number of non-participating hospitals has declined since then, there are still hundreds of hospitals for which TLG issues Hospital Safety Grades but which do not in fact provide survey data to TLG. In 2025, of the approximately 3,000 hospitals that TLG scored, approximately 2,300 participated in its hospital survey, meaning that roughly 23% chose not to participate.⁷⁶ For all such non-participating hospitals, TLG prominently displays a letter grade on its [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org) website, but on its

manager's time and the majority of those people were department heads." Marjorie A. Erdmann et al., "Transparency in Hospital Safety: A field study of 'what it takes' for hospitals to complete the Leapfrog Group Hospital Survey," *Oklahoma State Medical Proceedings*, 8(1), (2024): pp. 1–18 ("Erdmann et al. (2024)"), pp. 2, 7. Among the public comments that TLG received on its Fall 2024 methodology changes, several hospitals commented that these changes would cause hospitals to reallocate significant resources to avoid TLG's non-participation penalty. See LEAPFROG00045043 – 4 at LEAPFROG00045044 ("The proposed changes to the Imputation Method would result in an inaccurate portrayal of the actual status of the patient safety structures and processes in place for the Leapfrog grade measures CPOE, BCMA, IPS, and Hand Hygiene at hospitals that choose not to expend the resources to submit a 2024 Leapfrog Hospital Survey and had not submitted a 2023 Leapfrog Hospital Survey."); LEAPFROG00044966 – 7 at LEAPFROG00044967 ("Leapfrog should consider moving towards one CPOE test for large hospital systems that utilize the same EMR. It is a large administrative burden to get all tests scheduled and completed in a short amount of time from April 1st to June 30th. The time commitment to complete the test for each hospital is extensive and requires numerous hours of high-salaried FTEs. The frequency requirement should also be re-evaluated as it is unlikely hospitals are changing their EMR significantly each year or every other year... The last-minute notice of changes [in the methodology] that negatively impact hospitals that do not submit requires rapid shifting of priorities for the FTEs heavily involved in survey submission. The completion of the survey requires a great deal of coordination between various departments across the hospital including Informatics, Physicians, Pharmacy, Women's Services, Quality & Safety, and Nursing."); LEAPFROG00178624 – 7.

⁷³ Spring 2025 TLG Scoring Methodology, pp. 4–8.

⁷⁴ There is a numerical score associated with each of the 12 measures that determines in which performance category a hospital is placed. "Achieved the Standard" is associated with a score of 100. "Considerable Achievement" is associated with a score of 50, 70, or 75, depending on the measure. "Some Achievement" is associated with a score of 15, 40, or 50, depending on the measure. "Limited Achievement" is associated with a score of 5, 15, or 25, depending on the measure. "Unable to Calculate Score" or "Does Not Apply" is recorded when a score is "Not Available." See Spring 2025 TLG Scoring Methodology, pp. 9–12.

⁷⁵ Only approximately 42% of hospitals TLG scored in 2013 participated in TLG's hospital survey. See Wenke Hwang et al., "Hospital Patient Safety Grades May Misrepresent Hospital Performance," *Journal of Hospital Medicine* 9(2) (2014): pp. 111–115 ("Hwang et al. (2014)"), p. 112.

⁷⁶ "About the Leapfrog Group," *The Leapfrog Group*, November 15, 2024, available at <https://www.hospitalsafetygrade.org/about-the-score/about-the-leapfrog-group> ("About the Leapfrog Group"); Spring 2025 TLG Scoring Methodology, p. 3.

leapfroggroup.org website TLG only states that these hospitals declined to participate in TLG's survey without displaying any letter grade.⁷⁷

43. In order to assign grades to non-participating hospitals, TLG uses other sources for the 12 measures that are based on survey responses for participating hospitals:⁷⁸ for five of the measures, TLG uses CMS data;⁷⁹ for three of the measures, TLG does not include the measure in calculating the hospital's Safety Grade;⁸⁰ and for four of the measures, TLG uses an "imputation model."⁸¹ The four measures for which TLG imputes values are:

1. Computerized Physician Order Entry ("CPOE")
2. Bar Code Medication Administration ("BCMA")
3. ICU Physician Staffing ("IPS")
4. Hand Hygiene Score ("HHS").

44. For these four measures, if a hospital does not participate in TLG's survey, TLG follows a two-step imputation model. Starting in the Fall of 2024, the imputation model consisted of the following. First, if the hospital had a prior score assigned by TLG in the last two rounds of hospital grade assignments, the hospital is assigned the same score as the most recent available score on that measure.⁸² If a hospital does not have historical data from the last two rounds of hospital grades, TLG assigns "a point value that is equivalent to receiving 'Limited Achievement' for this measure," which is the lowest possible score a hospital can

⁷⁷ See, e.g., "West Boca Medical Center," *The Leapfrog Group*, available at <https://www.hospitalsafetygrade.org/h/west-boca-medical-center>; "West Boca Medical Center," *The Leapfrog Group*, available at <https://ratings.leapfroggroup.org/facility/details/10-0268/west-boca-medical-center-boca-raton-fl>; "Good Samaritan Medical Center," *The Leapfrog Group*, available at <https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center>; "Good Samaritan Medical Center," *The Leapfrog Group*, available at <https://ratings.leapfroggroup.org/facility/details/10-0287/good-samaritan-medical-center-west-palm-beach-fl>; "St. Mary's Medical Center," *The Leapfrog Group*, available at <https://www.hospitalsafetygrade.org/h/st-marys-medical-center-west-palm-beach-fl>; "St. Mary's Medical Center," *The Leapfrog Group*, available at <https://ratings.leapfroggroup.org/facility/details/10-0288/st-mary-s-medical-center-west-palm-beach-fl>; "Delray Medical Center," *The Leapfrog Group*, available at <https://www.hospitalsafetygrade.org/h/delray-medical-center>; "Delray Medical Center," *The Leapfrog Group*, available at <https://ratings.leapfroggroup.org/facility/details/10-0258/delray-medical-center-delray-beach-fl>; "Palm Beach Gardens Medical Center," *The Leapfrog Group*, available at <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>; "Palm Beach Gardens Medical Center," *The Leapfrog Group*, available at <https://ratings.leapfroggroup.org/facility/details/10-0176/palm-beach-gardens-medical-center-palm-beach-gardens-fl>.

⁷⁸ For participating hospitals that decline to provide information on specific measures, TLG applies the same methodology for those measures that it does for non-participating hospitals. See Spring 2025 TLG Scoring Methodology, pp. 4–6, 9–15, 23.

⁷⁹ These five measures are Central Line-Associated Bloodstream Infections ("CLABSI"), Catheter-Associated Urinary Tract infections ("CAUTI"), Surgical Site Infections from Colon Surgery ("SSI: Colon"), Facility-Wide Inpatient MRSA Blood Laboratory-Identified Events ("MRSA"), and Facility-Wide Inpatient C.diff. Laboratory-identified Events ("C. Diff."). See Spring 2025 TLG Scoring Methodology, p. 6.

⁸⁰ These three measures are Total Nursing Care Hours per Patient Day, Safe Practice 1: Culture of Leadership Structures and Systems ("SP 1"), and Safe Practice 2: Culture Measurement, Feedback & Intervention ("SP 2"). Given that these three measures are excluded for non-participating hospitals, the standard weights of these measures are redistributed to the other measures for which there are data. Spring 2025 TLG Scoring Methodology, pp. 4–5, 20, 23.

⁸¹ Spring 2025 TLG Scoring Methodology, pp. 4–5.

⁸² Step 1 imputation is temporarily on pause for the BCMA measure due to changes TLG made to the measure in 2024. See "Final Updates to the Leapfrog Hospital Safety Grade Methodology for Fall 2024," *The Leapfrog Group*, available at https://www.hospitalsafetygrade.org/media/file/Fall2024HospitalSafetyGrade_FinalMethodologyChanges.pdf ("Final Updates to Fall 2024 TLG Scoring Methodology"), pp. 2–3. See also Spring 2025 TLG Scoring Methodology, p. 15.

receive.⁸³ For the CPOE measure, the “Limited Achievement” value is 15, for the BCMA measure it is 25, for IPS it is 5, and for HHS it is 15.⁸⁴ Thus, hospitals that choose not to participate in TLG’s survey receive only 60 out of 400 possible points for these four measures combined. By contrast, hospitals that choose to participate in TLG’s survey have an average of 302 points for these four measures combined.⁸⁵ This difference of 242 points has a considerable impact on a hospital’s safety grade. Based on the Spring 2025 safety grade criteria, the 242-point difference can correspond to an average grade that is one letter worse for non-participating hospitals, relative to the average letter grade received by participating hospitals, even if both types of hospitals received identical scores across all other measures.⁸⁶

45. Note that prior to the Fall of 2024, TLG used a substantially different imputation model for non-participating hospitals that did not have a recent TLG-assigned score on these four measures.⁸⁷ Specifically, rather than assign such non-participating hospitals the lowest possible score on these four measures (as it does now), TLG previously assigned these hospitals the average score reported by a set of similar participating hospitals, based on comparison of various hospital characteristics such as urban/rural status and number of beds.⁸⁸

46. TLG states that its Hospital Safety Grades are based on a public and peer-reviewed methodology under the guidance of a “National Expert Panel,” comprised of academics and researchers.⁸⁹ However, the study that TLG refers to as “peer reviewed and published in the Journal of Patient Safety” was published more than a decade before TLG changed its imputation model in Fall 2024.⁹⁰ Thus, this study did not take into consideration TLG’s current imputation methodology. Furthermore, both TLG’s earlier and current

⁸³ Spring 2025 TLG Scoring Methodology, pp. 9–12, 16; See Final Updates to Fall 2024 TLG Scoring Methodology, pp. 2–3.

⁸⁴ Spring 2025 TLG Scoring Methodology, p. 16.

⁸⁵ Spring 2025 TLG Scoring Methodology, p. 22.

⁸⁶ Note that TLG may set different Hospital Safety Grade cut-points for different years. In my calculation, I use the Spring 2025 grade cut-points and TLG’s methodology to standardize scores in order to determine the Hospital Safety Grades for participating and non-participating hospitals. See Workpaper 1; “Key Dates and Information,” *The Leapfrog Group*, available at <https://www.hospitalsafetygrade.org/for-hospitals/key-dates-and-information>; “Explanation of Hospital Safety Grades,” *The Leapfrog Group*, April 2025, available at https://www.hospitalsafetygrade.org/media/file/ExplanationofSafetyGrades_Spring2025.pdf, p. 2.

⁸⁷ If hospitals had an assigned score in any of the previous four rounds (i.e. two years) of grades, instead of previous two rounds of grades as is done currently, TLG would impute the most recent score. See “Leapfrog Hospital Safety Grade Scoring Methodology,” *The Leapfrog Group*, April 22, 2024, available at <https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Methodology-Spring-2024.pdf> (“Spring 2024 TLG Scoring Methodology”), p. 14.

⁸⁸ This average score second imputation step applies to CPOE, BCMA, and HHS. For IPS, if hospitals reported at least one ICU bed in CMS, TLG assigned non-participating hospitals the lowest possible score. See Final Updates to Fall 2024 TLG Scoring Methodology, p. 2; Spring 2024 TLG Scoring Methodology, pp. 14, 17.

⁸⁹ FAQ About TLG Hospital Safety Grade; “About the Grade,” *The Leapfrog Group*, available at <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/about-the-grade> (“TLG About the Grade”).

⁹⁰ TLG About the Grade; J. Matthew Austin et al., “Safety in Numbers: The Development of Leapfrog’s Composite Patient Safety Score for U.S. Hospitals,” *Journal of Patient Safety* 9 (2013): pp. 1–9, available at https://www.hospitalsafetygrade.org/media/file/JournalofPatientSafety_HospitalSafetyScore.pdf.

imputation models conflict with the guidance of TLG's Expert Panel. Because "not all hospitals have enough data publicly available to be eligible for a grade," the Expert Panel's guidance states that there are "requirements for the minimum amount of data [TLG] need[s] to issue an accurate grade."⁹¹ More specifically, the guidance states that "[a] hospital must have enough safety data available for our experts to issue them a letter grade. Hospitals missing more than **six** process measures" are "not graded."⁹² Yet, TLG assigns non-participating hospitals grades even though, without TLG's imputation model, these non-participating hospitals would lack data for **seven** of the twelve process measures.

47. The remaining 10 of the 22 patient safety measures underlying TLG's Hospital Safety Grade come from CMS data.⁹³ CMS collects and maintains data through the HQI, a CMS program that collects and distributes data on hospital performance and other metrics, and these data are fundamentally different from TLG's hospital survey data.⁹⁴ First, CMS data have mandatory reporting standards. Hospitals that fail to publicly report data to CMS may receive reduced Medicare Fee-for-Service payments, a program that "pays physicians, hospitals, and other health care facilities based on statutorily established payment systems."⁹⁵ Second, CMS hospital data are audited, and hospitals that "fail to report information in a timely, accurate, or complete manner" may be penalized.⁹⁶ In some cases, CMS may conduct additional "quality oversight activities, including inspection of survey administration procedures, statistical analyses of submitted data, and site visits of ... survey vendors and self-administering hospitals."⁹⁷ By contrast, TLG's hospital survey data are self-reported with hundreds of hospitals declining to participate, and the available TLG data documentation do not mention any auditing of the survey responses. According to a 2019 evaluation of TLG's methodology conducted by a group of physician scientists, TLG audits very few hospitals: "[TLG] leadership stated that they had only done a formal audit for approximately five hospitals of about 2,600 in the past year, and only 72 hospitals underwent an electronic audit."⁹⁸

⁹¹ FAQ About TLG Hospital Safety Grade.

⁹² TLG About the Grade.

⁹³ Spring 2025 TLG Scoring Methodology, pp. 5–7.

⁹⁴ CMS Hospital Quality Initiative.

⁹⁵ "Finding Medicare Fee-For-Service (FFS) Payment System Rules: Schedules and Resources," *Congress.gov*, January 7, 2025, available at <https://www.congress.gov/crs-product/R46797>; "Hospital Quality Initiative Public Reporting," *CMS.gov*, September 10, 2024, available at <https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hospital-compare>. For example, the HCAHPS survey, which includes five of the ten CMS patient safety measures in TLG's survey, requires such reporting, and "hospitals that fail to publicly report the quality measures, which include the HCAHPS survey, may receive a reduced annual payment." See CMS HCAHPS: Patients' Perspectives of Care Survey.

⁹⁶ CMS Audits and Penalties.

⁹⁷ CMS HCAHPS: Patients' Perspectives of Care Survey.

⁹⁸ Karl Y. Bilimoria et al., "Rating the Raters: An Evaluation of Publicly Reported Hospital Quality Rating Systems," *NEJM Catalyst* 5(4) (2019), p. 14.

48. After TLG compiles the 22 measures for each hospital, it produces a standardized score, which allows it to assign a Hospital Safety Grade for each hospital. To standardize data from measures with different performance scales, TLG converts each measure's value to a z-score. A z-score is calculated using a hospital's actual measure score, the national mean for that measure, and the national standard deviation for that measure.⁹⁹ Specifically, for process measures, z-scores are calculated as $(\text{Hospital Score} - \text{Mean}) / \text{Standard Deviation}$, and for outcome measures, z-scores are calculated as $(\text{Mean} - \text{Hospital Score}) / \text{Standard Deviation}$.¹⁰⁰

49. TLG then calculates an overall numerical score for each hospital. First, TLG multiplies the z-score for each measure by the weight assigned to that measure. Then, TLG sums the weighted scores for each measure and adds 3, to normalize scores to a positive distribution. Lastly, the overall standardized numerical score (typically between 1.0 and 4.0) is converted into a Hospital Safety Grade.¹⁰¹

50. Additionally, TLG assigns standard weights to all 22 measures. TLG's methodology to assign standard weights includes four criteria: "Evidence," "Impact," "Opportunity," and "Number of Component Measures."¹⁰² These four criteria are then combined to produce a standard weight for each measure that represents the measure's relative importance within the Hospital Safety Grade.¹⁰³ After incorporating these weights, the 10 measures taken from CMS data account for *less than* 44% of the overall Hospital Safety Grade while the remaining 12 measures from TLG's hospital survey account for *more than* 56% of the overall Hospital Safety Grade.¹⁰⁴ The four measures for which TLG uses its imputation model for non-participating hospitals alone account for 24% of the overall Hospital Safety Grade.¹⁰⁵

⁹⁹ Spring 2025 TLG Scoring Methodology, p. 21.

¹⁰⁰ There are 12 process/structural measures: CPOE, BCMA, IPS, SP 1, SP 2, Total Nursing Care Hours per Patient Day, HHS, H-COMP-1, H-COMP-2, H-COMP-3, H-COMP-4, H-COMP-5, and H-COMP-6. There are 10 outcome measures: Foreign Object Retained, Air Embolism, Falls and Trauma, CLABSI, CAUTI, SSI: Colon, MRSA, C. Diff., PSI 4, and PSI 90. Spring 2025 TLG Scoring Methodology, pp. 20–21.

¹⁰¹ Spring 2025 TLG Scoring Methodology, p. 24.

¹⁰² The Evidence Score is determined by the strength and quality of the evidence that supports the measure. The Impact Score is a function of the number of patients affected and the severity of harm. The Opportunity Score is based on the Coefficient of Variation of that measure, calculated as $1 + (\text{Standard Deviation} / \text{Mean})$. The Number of Component Measures simply reflects how many component measures comprise the measure. For PSI 90, the number of component measures is 10 and for all other measures, the number of component measures is one. Spring 2025 TLG Scoring Methodology, pp. 18–19.

¹⁰³ Standard Weight = Evidence + (Impact x Opportunity x Number of Component Measures); Spring 2025 TLG Scoring Methodology, pp. 18–20.

¹⁰⁴ Workpaper 2.

¹⁰⁵ Workpaper 2. If any of the measures are missing for a given hospital, the standard weight of that measure is redistributed to the other measures for which there are data. Spring 2025 TLG Scoring Methodology, pp. 20, 23–24.

X. TLG's Rating Methodology Is Fundamentally Flawed

51. In Section VII, I described important guiding principles for measuring hospital quality. TLG's hospital rating system departs from these established principles, resulting in ratings that are unreliable and incapable of predicting actual patient outcomes.

A. TLG's Methodology for Generating Hospital Grades Fails to Provide an Appropriate Basis for Comparison of Hospitals

52. As discussed in Section VII, for a rating system to allow for meaningful comparisons across the entities being ranked, the methodology used to determine ratings should be consistently applied across all entities.¹⁰⁶ In other words, if ratings were to be generated using different methodologies across different entities, such ratings would not actually allow different entities to be meaningfully compared to one another. TLG's methodology for generating hospital grades suffers from this fundamental flaw.

53. As discussed in Section IX, participation in TLG's survey is voluntary, and while the rate of non-participation has decreased over time from more than 50% in 2013 to approximately 23% in 2025, it still remains the case that many hospitals for which TLG provides safety grades choose to submit no information at all as part of TLG's hospital survey.¹⁰⁷ The statistics literature has found that the quality of inferences that can be drawn based on available data is directly related to the proportion of missing data, and that any "statistical analysis is likely to be biased when more than 10% of the data are missing."¹⁰⁸ As such, the fact that TLG continues to generate hospital grades for hundreds of hospitals that provide no survey responses and represent approximately 23% of all hospitals that TLG grades calls into question the scientific reliability of TLG's hospital grades.

54. The unreliability of TLG's hospital grades is further underscored by the fact that the major contributor of these hospital grades (56.6% of the overall grade) is the collective 12 measures that participating hospitals self-report in TLG's survey and non-participating hospitals do not. As discussed in Section IX, TLG applies a different rating methodology for participating hospitals versus non-participating hospitals with respect to these 12 measures. For participating hospitals, these 12 measures are based on non-audited, self-reported values

¹⁰⁶ For example, as part of the HCAHPS program, CMS also conducts "quality oversight activities, including inspection of survey administration procedures, statistical analyses of submitted data, and site visits of HCAHPS survey vendors and self-administering hospitals, to assure that the HCAHPS survey is being administered according to the protocols." Similarly, in the article that will be published later this year, my co-authors and I independently audit data underlying our research to ensure data reporting is consistent across different health plans and compliant with required data specifications. *See* CMS HCAHPS: Patients' Perspectives of Care Survey; Stankaitis, Singh and Nicholson (2025).

¹⁰⁷ Hwang et al. (2014), p. 112; About the Leapfrog Group; Spring 2025 TLG Scoring Methodology, p. 3.

¹⁰⁸ Yiran Dong and Chao-Ying Joanne Peng, "Principled missing data methods for researchers," *SpringerPlus* 2(222) (2013): pp. 1–17, p. 2.

obtained from TLG's hospital survey, whereas for non-participating hospitals five of these measures are based on audited, mandatory reported values from public sources, four are "imputed" as the lowest possible score,¹⁰⁹ and three are not considered when calculating the safety grade.¹¹⁰ Academic literature has raised similar concerns about the reliability of TLG's methodology due to different treatment of participating and non-participating hospitals, even before TLG's methodology update in Fall 2024 regarding the imputation model used for non-participating hospitals.¹¹¹

55. Further, for some of the measures that are obtained from public sources for both participating and non-participating hospitals, these measures are obtained from *different* public sources for the different type of hospital. For example, the standardized infection ratio ("SIR") measure, which accounts for 21.6% of a hospital's grade, is obtained from CMS for non-participating hospitals, while it is obtained using the National Healthcare Safety Network ("NHSN") data for participating hospitals.¹¹² Although data should be similar from both sources, it is well acknowledged that the data often do not match in practice,¹¹³ and TLG has made public recognition of this fact.¹¹⁴ Namely, TLG acknowledges that SIR data obtained from CMS and NHSN often do not match, because CMS data are "frozen based on the quarterly

¹⁰⁹ In the event that a hospital had a score assigned by TLG in the previous two rounds of grades, excluding imputed scores, the most recent score is used instead of this imputation.

¹¹⁰ Spring 2025 TLG Scoring Methodology, pp. 15–17. In its Motion to Dismiss, TLG claims that "government entities implement a similar methodological approach to missing data" as TLG's imputation model, and identifies (1) the U.S. Census Bureau, (2) the U.S. Bureau of Labor Statistics ("BLS"), and (3) the U.S. Bureau of Justice Statistics ("BJS") as the relevant agencies. Defendant The Leapfrog Group's Motion to Dismiss Pursuant to Federal Rule of Civil Procedure 12(b)(2) and 12(b)(6) and Incorporated Memorandum of Law in Support of the Same, *Good Samaritan Medical Center, et al. v. The Leapfrog Group*, Case No. 9:25-cv-80526-DMM, June 27, 2025. However, TLG's current imputation model, which assigns the lowest possible score to missing survey responses, does not conform to the methods implemented by those government entities. None of these entities assign the *lowest* values in cases of missing data as TLG does. Rather, they apply common imputation methods. For example, one of the methods the BLS uses in its Import and Export Price Index survey is "cell mean imputation" that utilizes information on average prices for items that have such available data to impute prices for other, similar items for which pricing information is not available. See "Data Editing and Imputation," *U.S. Census Bureau*, available at <https://www.census.gov/programs-surveys/sipp/methodology/data-editing-and-imputation.html>; Marcus Berzofsky et al., "Estimation Procedures for Crimes in the United States Based on NIBRS Data," *Bureau of Justice Statistics*, August 2022, available at <https://bjs.ojp.gov/content/pub/pdf/epcusbnibrsd.pdf>, pp.4–5; "Discussion" under "Guidelines for Data Transparency, Analysis, and Processing" in "Data Quality Guidelines Overview," *U.S. Bureau of Justice Statistics*, available at <https://bjs.ojp.gov/bjs-data-quality-guidelines/overview#22-0>; "Imputation," *U.S. Bureau of Labor Statistics*, available at <https://www.bls.gov/opub/hom/topic/imputation.htm>; , "International Price Program: Calculation," *U.S. Bureau of Labor Statistics*, available at <https://www.bls.gov/opub/hom/ipp/calculation.htm#estimating-missing-values>.

¹¹¹ See, e.g., Karl Y. Bilimoria et al., "Rating the Raters: An Evaluation of Publicly Reported Hospital Quality Rating Systems," *NEJM Catalyst* 5(4) (2019), p. 14; Shawna N. Smith et al., "Dissecting Leapfrog: How Well Do Leapfrog Safe Practices Scores Correlate with Hospital Compare Ratings and Penalties, and How Much Do They Matter?" *Medical Care* 55(6) (2017): pp. 606–614 ("Smith et al. (2017)"), p. 613; Hwang et al. (2014), p. 111; Erdmann et al. (2024), pp. 9–10.

¹¹² Spring 2025 TLG Scoring Methodology, pp. 13–15. See also "Leapfrog Hospital Survey Hard Copy," *The Leapfrog Group*, May 2, 2025, available at https://www.leapfroggroup.org/sites/default/files/Files/2025%20HospitalSurvey_20250502_v9.1%20%28version%20%29.pdf, p. 267.

¹¹³ "CMS Quality Reporting Programs Frequently Asked Questions," *CDC*, March 15, 2023, available at https://www.cdc.gov/nhsn/faqs/cms/faq_cms_hai.html.

¹¹⁴ NHSN Guidance (2025), pp. 19–20.

reporting deadline, whereas NHSN is constantly changing if a hospital changes its data.”¹¹⁵ In other words, participating hospitals are permitted to retroactively adjust their SIR data, but non-participating hospitals are not provided this same opportunity. Research has shown that participating hospitals’ SIR data are substantially more favorable than the SIR data publicly available through CMS, leading researchers to recommend that TLG use CMS data for all hospitals.¹¹⁶ TLG does not explain why it chooses this inconsistent methodology between participating and non-participating hospitals, instead of using CMS data for all hospitals. These inconsistent methodological practices of TLG in generating ratings preclude the ability to perform an apples-to-apples comparison of participating and non-participating hospitals.

56. Yet another inconsistency in how TLG treats participating and non-participating hospitals is that the former are graded based on (self-reported) performance during a more recent period than the latter. For example, as noted by TLG in its scoring methodology for Spring 2025, TLG used data on participating hospitals’ self-reported performance during July 2023–June 2024 on a variety of measures including measures of the incidence of five different types of infections that patients can develop while treated in the hospital.¹¹⁷ By comparison, for non-participating hospitals TLG used data from CMS on these measures even though those data were reported to CMS for a different time period—January–December 2023.¹¹⁸ In other words, in addition to relying on data from different *sources* for participating and non-participating hospitals, TLG also relies on data from different *time periods* for these two types of hospitals. Such a methodological inconsistency further undermines the ability of TLG’s resulting hospital grades to capture quality differences across hospitals.

57. Finally, even among hospitals that do participate in TLG’s survey, the hospital grades are not comparable. This is because the 12 measures that are derived from hospital responses to TLG’s survey are self-reported and hospitals are provided no uniform rubric to generate these responses. For example, the “National Quality Forum (‘NQF’) Safe Practices” measure is only defined by TLG as “measur[ing] a hospital’s progress towards implementing endorsed processes and protocols to reduce and prevent adverse events.”¹¹⁹ It is not clear what exactly constitutes an adverse event, nor how one might measure progress towards reducing incidence of such events. As another example, TLG defines the BCMA measure as measuring,

¹¹⁵ NHSN Guidance (2025), p. 20.

¹¹⁶ Smith et al. (2017), p. 613.

¹¹⁷ Spring 2025 TLG Scoring Methodology, p. 6.

¹¹⁸ Spring 2025 TLG Scoring Methodology, p. 6.

¹¹⁹ Spring 2025 TLG Scoring Methodology, p. 11.

in part, a hospital's progress towards "implementation of BCMA throughout the hospital" and "structures to monitor and reduce workarounds."¹²⁰ Again, TLG provides no rubric or specifics regarding how progress should be measured and provides no indication of what types of structures would need to be in place. For example, one first-time participating hospital reported "[s]urvey item interpretation problems" because the "[l]anguage of some of the sections and clarifications were confusing" such that "[i]t remains unclear how some of the measures are interpreted by other [hospital] systems."¹²¹ That hospital identified TLG's "Emphasis on Self-Reported Data" as a "Perceived Threat[] to Survey Validity" for these reasons.¹²² To the extent hospitals are reporting these scores using different informal rubrics, the resulting overall grades are not comparable across hospitals.

B. TLG's Rating System Results in Inappropriately Inflated Grades for Hospitals that Choose to Participate in Its Survey and Inappropriately Deflated Grades for Hospitals that Choose Not to Participate

58. As described in Section IX, for hospitals that choose to participate in TLG's survey, 12 of the 22 measures used to determine the hospital safety grade are based on self-reporting by these hospitals. TLG lacks an appropriate auditing mechanism to ensure that the self-reported data are accurate. For example, and as noted above, one such measure in the hospital survey is the HHS.¹²³ However, it is simply not possible to verify that each doctor or nurse at participating hospitals was washing their hands whenever they claim they did. Similarly, as noted above, another measure in the survey is "National Quality Forum Safe Practices," which purports to capture a hospital's progress toward implementing certain safety protocols.¹²⁴ But TLG has no way of independently verifying that a hospital truly practices any such protocols.

59. Participating hospitals are strongly incentivized to give themselves higher scores on these self-reported measures to improve their grades,¹²⁵ and in fact, Smith et al. (2017), examining TLG's hospital grades, concluded that participating hospitals do indeed inflate their responses to the survey, as evidenced by the fact that, on all but one measure, 50% or more of participating hospitals self-report a perfect score, as shown in Exhibit 1.¹²⁶ Based on my analysis of the data produced by TLG in this matter, I find that in the last available round

¹²⁰ Spring 2025 TLG Scoring Methodology, p. 9.

¹²¹ Erdmann et al. (2024), Table 2, p. 7.

¹²² Erdmann et al. (2024), Table 4, p. 11.

¹²³ Spring 2025 TLG Scoring Methodology, p. 12.

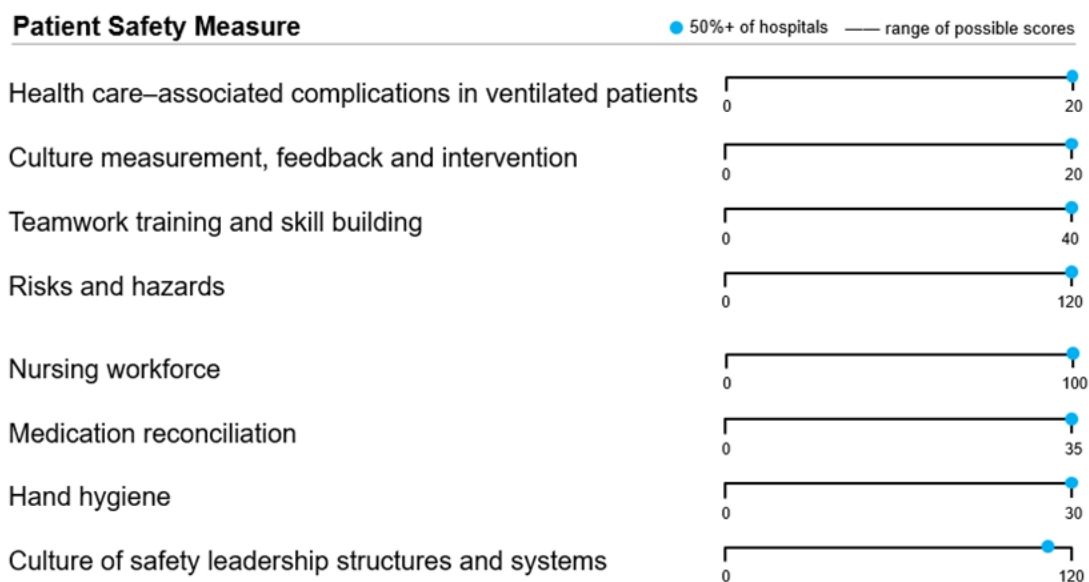
¹²⁴ Spring 2025 TLG Scoring Methodology, p. 11.

¹²⁵ Smith et al. (2017), p. 611.

¹²⁶ Smith et al. (2017), p. 609.

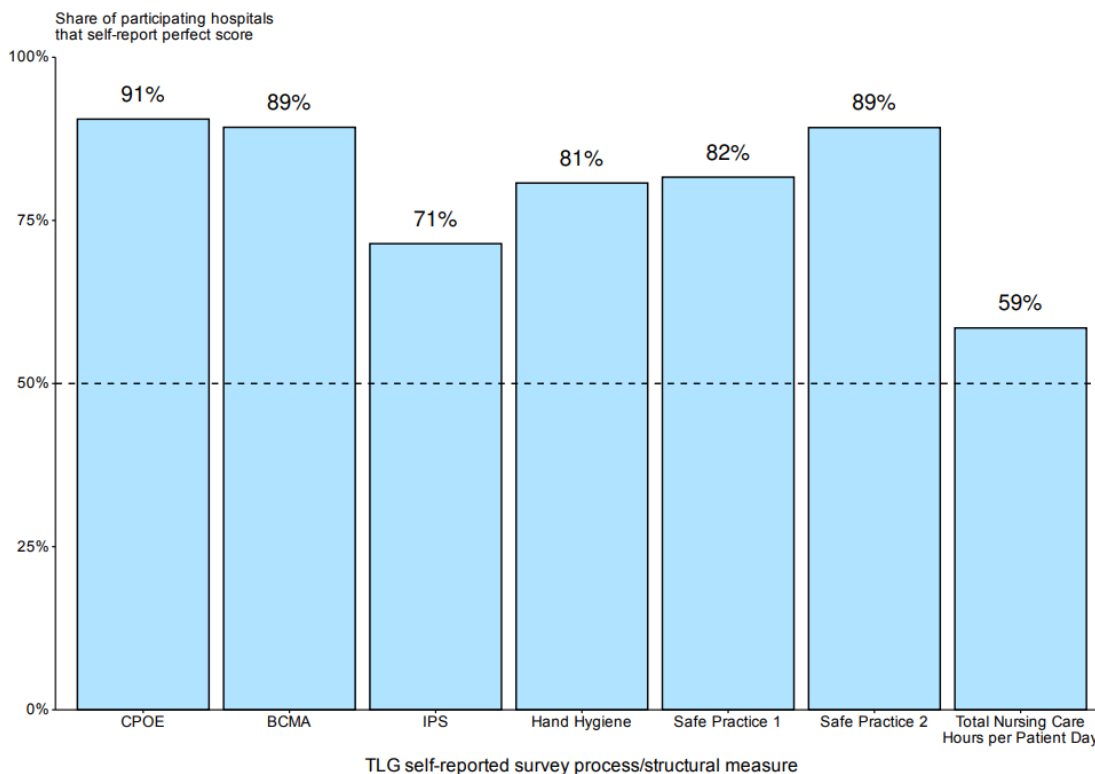
of TLG's survey, participating hospitals still tend to give themselves the highest possible score on the self-reported process measures. Exhibit 2 shows the percentage of participating hospitals that assigned themselves the highest possible score across the seven self-reported process measures in the Spring 2025 TLG survey. For each measure, the majority of participating hospitals assigned themselves the highest possible score. In fact, for six out of the seven measures, the share of participating hospitals that self-reported the highest possible score is greater than 70%. Another way to illustrate the large discrepancy between the scores that participating hospitals give themselves and the scores that TLG imputes for non-participating hospitals is to compare the average scores for the four imputed measures among non-participating hospitals with the average scores that were self-reported by participating hospitals where, for illustration, both averages are compared relative to the minimum and maximum possible score for each measure. As Exhibit 3 demonstrates, non-participating hospitals are given the lowest possible scores by TLG while participating hospitals consistently give themselves either the maximum scores or very close to them.

Exhibit 1
On Nearly All TLG Measures, 50% or More of Participating Hospitals Self-Report Perfect Scores



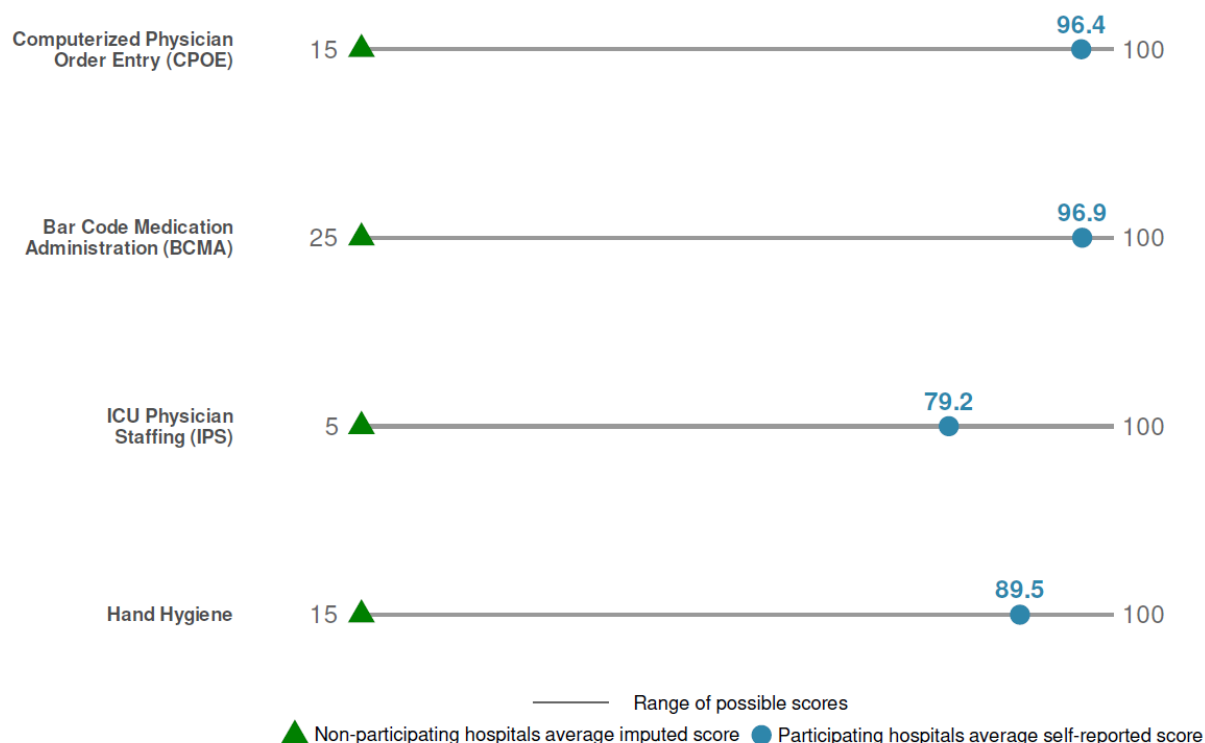
Source: Smith et al. (2017)

Note: This exhibit includes all eight patient safety measures included in the 2013 TLG Hospital Survey for which hospitals participating in the survey were asked to self-report. These measures combined contributed 22.6% a hospital's safety grade.

Exhibit 2***Most Participating Hospitals Continue to Self-Report Perfect Scores as of Spring 2025***

Source: TLG Hospital Safety Grade data

Note: This figure demonstrates that on each of the seven of the total 12 measures that hospitals participating in TLG's survey self-reported in Spring 2025, the majority of participating hospitals reported a perfect score. These seven measures are the ones that for non-participating hospitals, TLG either imputes the lowest possible value (Computerized Physician Order Entry (CPOE), Bar Code Medication Administration (BCMA), ICU Physician Staffing (IPS), Hand Hygiene) or omits in the calculation of the final grade (Safe Practice 1: Culture of Safety Leadership Structures and Systems, Safe Practice 2: Culture Measurement, Feedback, and Intervention, and Total Nursing Care Hours per Patient Day). This analysis does not include non-participating hospitals that were subject to TLG's "Step 1" imputation, which uses historical data to calculate a previously participating hospital's score on a given measure.

Exhibit 3***TLG Assigns Non-Participating Hospitals the Lowest Possible Scores on Four Process Measures While Participating Hospitals Self-Report Very High Scores***

Source: TLG Hospital Safety Grade data

Note: This figure shows the four measures for which TLG imputes the score for non-participating hospitals. Specifically, it shows the average score that TLG imputed for non-participating hospitals and the average score that participating hospitals self-reported in Spring 2025. The non-participating hospitals included in the figure do not include non-participating hospitals for which TLG applies “Step 1” imputation, where TLG uses historical data to calculate a previously participating hospital’s score on a given measure. TLG’s “Step 1” imputation affects 38 out of 592 non-participating hospitals.

60. Further, Smith et al. (2017) found a “consistently weak” correlation between these *self-reported* scores and a set of *actual* patient outcomes such as incidence of two different types of infection rates and incidence of hospital penalties due to high rates of unplanned patient readmissions and hospital-acquired conditions (“HAC”),¹²⁷ meaning that hospitals that self-report inflated scores provide no observable benefit to patients with respect to these outcomes as compared to non-participating hospitals.¹²⁸ As such, given that TLG

¹²⁷ In 2012, CMS began their HRRP and HACRP, which aim to reduce unplanned readmissions and HAC, respectively. Hospitals whose HAC or readmissions exceed expected values could be penalized up to 1% of total hospital Medicare reimbursement under HACRP or up to 3% of total hospital Medicare reimbursement under HRRP. See “Hospital Readmissions Reduction Program (HRRP),” *CMS.gov*, September 10, 2024, available at <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-readmissions-reduction-program-hrrp>. See also “Hospital-Acquired Condition Reduction Program,” *CMS.gov*, September 10, 2024, available at <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-acquired-condition-reduction-program-hacrp>.

¹²⁸ Smith et al. (2017), p. 611.

cannot verify the accuracy of survey responses and the fact that participating hospitals inflate their scores, this results in overall TLG grades that are inflated for participating hospitals.

61. Likewise, exactly the opposite is true for non-participating hospitals. Contrary to TLG's claim that "Hospital Safety Grades are not... automatically lowered if a hospital declines to participate,"¹²⁹ TLG's methodology does in fact "automatically" penalize hospitals that do not respond to the survey by inappropriately deflating those hospitals' grades. This occurs primarily through TLG's imputation model, adopted in the Fall of 2024 as discussed in Section IX, which assigns non-participating hospitals the *lowest possible score*, associated with "Limited Achievement," for four measures without having any factual basis to do so.¹³⁰ As also discussed above, this imputation model has an outsized impact on a hospital's safety grade and can lead to a non-participating hospital receiving a safety grade that is one letter grade lower than an otherwise identical participating hospital.

62. As an example, the Spring 2025 TLG grades for Florida hospitals demonstrate the marked difference in grades between participating and non-participating hospitals. *Every* hospital in Florida that received a grade of "A" or "B" from TLG had completed TLG's survey, and *every* hospital in Florida that did not complete the survey received a grade of "C" or lower.¹³¹ Moreover, the majority of these Florida hospitals that received a grade of "A" or "B" from TLG received CMS Overall Hospital Quality Star Ratings below the national average of 3.1 stars (out of five).¹³² This provides another example of how participation in TLG's survey may result in inflated TLG grades.

63. Even prior to adopting this imputation model in the Fall of 2024, TLG's methodology penalized non-participating hospitals. For example, for two of the measures for

¹²⁹ "Follow-Up Statement from Leapfrog President and CEO Leah Binder on Tenet Healthcare Hospitals' Lawsuit to Suppress Poor Safety Grade Performance," *The Leapfrog Group*, May 2, 2025, available at <https://www.leapfroggroup.org/news-events/follow-statement-leapfrog-president-and-ceo-leah-binder-tenet-healthcare-hospitals%E2%80%99>.

¹³⁰ "Leapfrog Hospital Safety Grade Scoring Methodology," *The Leapfrog Group*, November 4, 2024, available at <https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024-1.pdf>, p. 15; Spring 2025 TLG Scoring Methodology, pp. 15–16.

¹³¹ "How Safe is Your Hospital?" *The Leapfrog Group*, available at <https://www.hospitalsafetygrade.org/>. See Workpaper 3. This pattern is present nationwide. My analysis of the data produced by TLG in this matter shows that in Spring 2025, among all U.S. hospitals that received TLG grades of "A" or "B", virtually all of them—98%—were hospitals that elected to complete TLG's survey. By contrast, among U.S. hospitals that received TLG grades of "C" or lower, only 54% completed the survey. Similar percentages were observed for Fall 2024—98% and 53%, respectively. In both years, the difference in percentages across differently graded hospitals is statistically significant, i.e., hospitals that receive higher grades by TLG are significantly more likely to be participating hospitals than hospitals that receive lower grades. Workpaper 6.

¹³² The CMS Overall Hospital Quality Star Rating is part of the HQL. See "Hospital Quality Initiative Public Reporting," *CMS.gov*, available at <https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hospital-compare>. This rating "summarizes a variety of measures across 5 areas of quality into a single star rating for each hospital." These 5 areas include "Mortality," "Safety," "Readmission," "Patient Experience," and "Timely & Effective Care." See "Overall Hospital Quality Star Rating," *Data.CMS.gov*, available at <https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating>. The national average CMS Overall Hospital Quality Star Rating is calculated across all U.S. hospitals that received a CMS star rating. Among Florida hospitals that received a TLG grade of A or B, more than 50 percent of hospitals received a CMS Overall Hospital Quality Star Rating of three or lower. See Workpaper 4.

which TLG currently imputes the lowest possible value for non-participating hospitals, TLG previously used data from another source (a survey administered by the American Hospital Association (“AHA”)) for non-participating hospitals.¹³³ This AHA survey, however, had a lower maximum possible score, so that even if a hospital scored the maximum points on the AHA survey, that score would still be lower than the maximum possible score on TLG’s survey.¹³⁴ TLG’s methodology did not take into account the different point scales for the two surveys, which resulted in non-participating hospitals having their scores appear inappropriately deflated relative to the scores of participating hospitals.¹³⁵

64. This inappropriate deflation of scores and resulting safety grades for non-participating hospitals was documented in Hwang et al. (2014), a study that examined TLG’s safety grades for 35 hospitals, all considered “top hospitals” according to a rating by the *U.S. News & World Report*,¹³⁶ but 17 of which did not participate in TLG’s hospital survey and 18 of which did. Unlike TLG, the study’s authors “rescored” the 17 non-participating hospitals by assigning them the average values of the self-reported measures of the 18 participating hospitals.¹³⁷ This rescoring allowed the non-participating hospitals to benefit from any score inflation inherent in the self-reported measures of the participating hospitals. It also allowed the non-participating hospitals to be shielded from any score deflation caused by TLG using a different scale with a lower possible maximum score for non-participating hospitals than for participating ones.

65. Hwang et al. (2014) found that virtually all (15 of the 17) non-participating hospitals would have obtained higher safety grades simply by virtue of participating in TLG’s survey, and eight of these hospitals would have received such a substantial improvement in

¹³³ See, e.g., “Hospital Safety Score Scoring Methodology,” *The Leapfrog Group*, May 2013, available at https://www.hospitalsafetygrade.org/media/file/HospitalSafetyScore_ScoringMethodology_May2013.pdf (“Spring 2013 TLG Scoring Methodology”), pp. 13–15.

¹³⁴ For the CPOE measure, participating hospitals were scored from 5 to 100, whereas non-participating hospitals were scored from 5 to a maximum of 65. Similarly, for the IPS measure, participating hospitals were scored from 5 to 100, whereas non-participating hospitals were scored from 5 to a maximum of 85. Spring 2013 TLG Scoring Methodology, pp. 13–15.

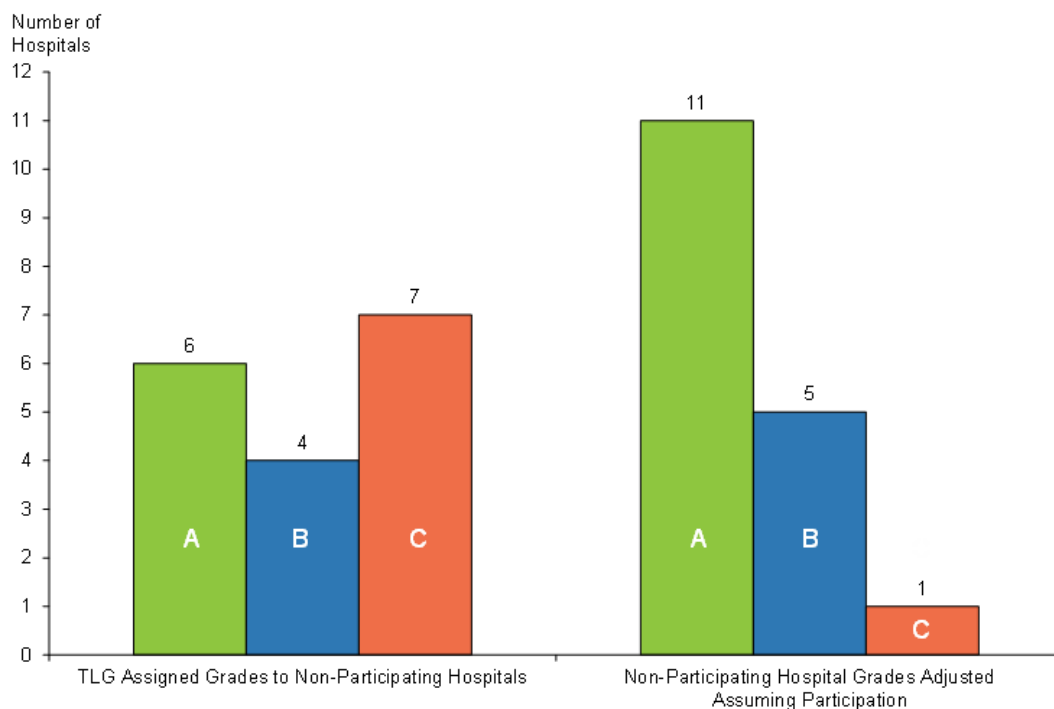
¹³⁵ In 2018, TLG lowered the maximum CPOE score for non-participating hospitals to 45 (from 65) using data from the AHA survey. In Spring 2021, TLG began applying its average score methodology to CPOE as described in Section IX above. In Fall 2023, TLG imputed the lowest IPS score of 5 for non-participating hospitals that reported having any ICU hospital beds to CMS. See Spring 2013 TLG Scoring Methodology, pp. 13–15; “Leapfrog Hospital Safety Score Scoring Methodology,” *The Leapfrog Group*, October 17, 2018, available at https://www.hospitalsafetygrade.org/media/file/HospitalSafetyGrade_ScoringMethodology_Fall2018_Final2.pdf, p. 14; “Leapfrog Hospital Safety Score Scoring Methodology,” *The Leapfrog Group*, November 17, 2020, available at https://www.hospitalsafetygrade.org/media/file/HospitalSafetyGrade_ScoringMethodology_Fall2020.pdf, pp. 15–17, 29; “Leapfrog Hospital Safety Score Scoring Methodology,” *The Leapfrog Group*, October 23, 2023, available at <https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Methodology-Fall2023.pdf>, pp. 15–18.

¹³⁶ The *U.S. News and World Report* Best Hospitals ratings evaluate nearly 6,000 hospitals each year, in collaboration with industry experts on a number of criteria for health outcomes, process, and structure measures. See “U.S. News Best Hospitals 2024-2025,” *U.S. News & World Report*, available at <https://health.usnews.com/best-hospitals>.

¹³⁷ Hwang et al. (2014), p. 112.

their safety grades that would have amounted to a one- or two- letter grade improvement, further demonstrating the bias in TLG's method of addressing missing data from non-participating hospitals.¹³⁸ Exhibit 4 displays the impact of the rescoring on the grades of non-participating hospitals.

Exhibit 4
Example of How TLG Penalized Non-Participating Hospitals Even Prior to Fall 2024



Source: Hwang et al. (2014).

Note: Displayed are the results of an analysis of TLG's hospital grades for 17 "top" hospitals (based on rating of the *US News and World Report*) all of which did not participate in TLG's hospital survey. Hwang et al. (2014) compared the actual hospital grades assigned to these hospitals by TLG (histogram on the left) with what grades these hospitals would have obtained had they participated in the survey (histogram on the right).

66. Using data produced by TLG in this matter, I conducted a similar rescoring exercise for all non-participating hospitals in the Spring of 2025, presented in Exhibit 5. Assuming that these hospitals chose to participate in TLG's survey and assigned themselves the average score that participating hospitals did for each of the seven self-reported measures in the survey, their performance would have improved substantially. Specifically, while 96% of these non-participating hospitals received a grade of "C" or lower, I find that had they participated and behaved like participating hospitals typically do, 71% of them would have

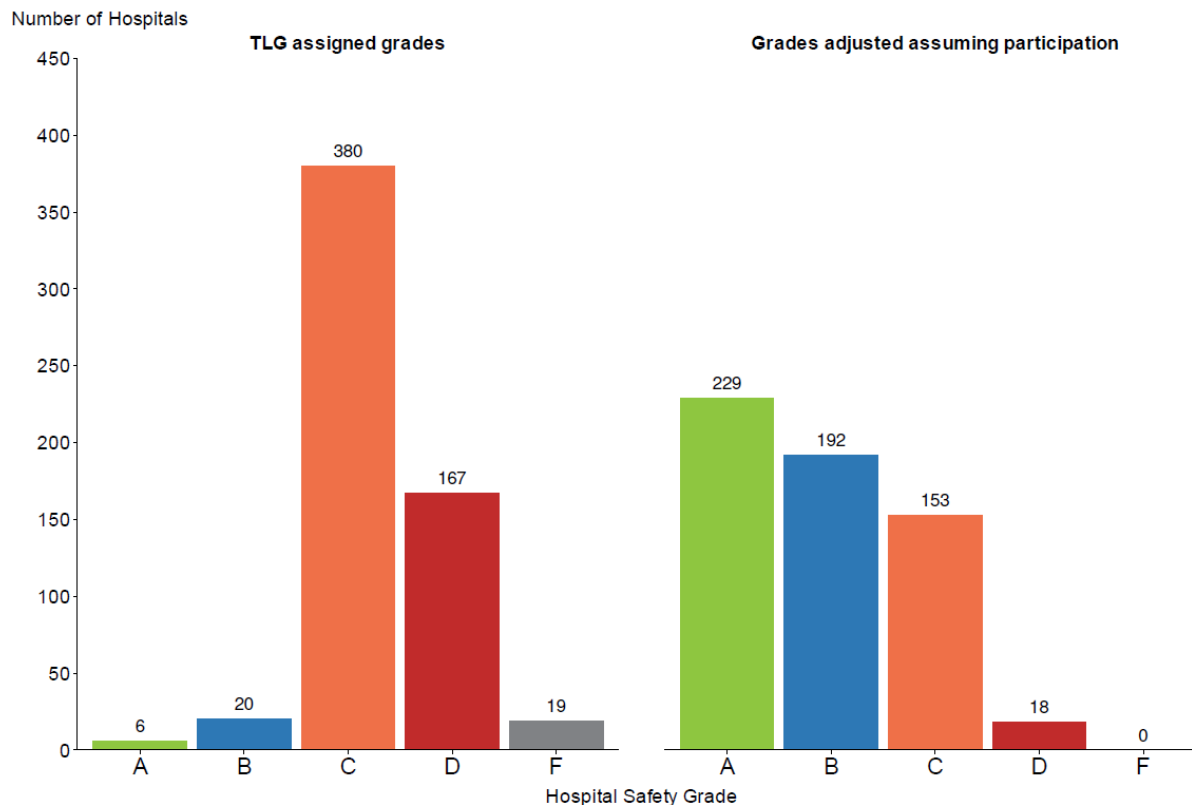
¹³⁸ Hwang et al. (2014), p. 113.

received grades of “A” or “B” instead.¹³⁹ I also conducted a similar rescoring exercise using the data provided by TLG for Plaintiffs for Spring 2025. Specifically, I compared the grades that TLG assigned to Plaintiffs with the grades that Plaintiffs would have been assigned had they participated in TLG’s survey and self-reported data in a similar way to participating hospitals, i.e., if they had given themselves the average score that participating hospitals gave themselves on each measure.¹⁴⁰ Exhibit 6 illustrates the impact of this rescoring exercise for Plaintiffs. As this Exhibit shows, had Plaintiffs chosen to participate in TLG’s survey and answered that survey in the way that participating hospitals do, Plaintiffs would have been assigned by TLG grades of “C”, i.e., one to two letter grades higher than the grades Plaintiffs were actually assigned when they chose not to participate in TLG’s survey.

¹³⁹ When conducting this exercise using hospital participation data for Fall 2024, I find very similar results. 94% of these non-participating hospitals received a grade of “C” or lower, but had they participated, 76% of them would have received grades of “A” or “B” instead. See Appendix D, Workpaper 7

¹⁴⁰ As noted in Smith et al. (2017), the median score, i.e., the score self-reported by 50% or more of the participating hospitals was the highest possible score for all but one measure. For that last measure, the median score was still very close to the maximum—111.43 points out of 120 maximum points. See Smith et al. (2017), Table 1, p. 609. When constructing the counterfactual scenario where Plaintiffs participate in TLG’s survey, I conservatively assume that Plaintiffs would have given themselves the *average* score that participating hospitals gave themselves on seven out of 12 measures—those seven measures for which TLG either imputes the lowest possible score for a non-participating hospital or which TLG disregards for non-participating hospitals (but includes for participating ones). For all other measures, I leave TLG’s scoring methodology unchanged. Using the average scores is conservative because, as noted above, even if not all, many participating hospitals self-report the highest possible scores for these seven measures. Using the average scores of participating hospitals is consistent with Hwang et al. (2014) who conduct a similar rescoring analysis of TLG grades and also assign the average scores of participating hospitals to non-participating hospitals. See Hwang et al. (2014), p. 112. Using average (otherwise known as “mean”) values of responding units (i.e., participating hospitals in this case) to impute missing data for non-responding units (i.e., non-participating hospitals) is a common method of handling missing data, supported by the academic statistics literature. See, e.g., Roderick J. A. Little and Donald B. Rubin, “Single Imputation Methods,” in *Statistical Analysis with Missing Data 3e* (Hoboken, NJ: Wiley, 2020), pp. 67–84, p. 68 (“Explicit modeling methods include the following: (a) *Mean imputation*: Where means from the responding units in the sample are substituted.”). See Workpaper 5.

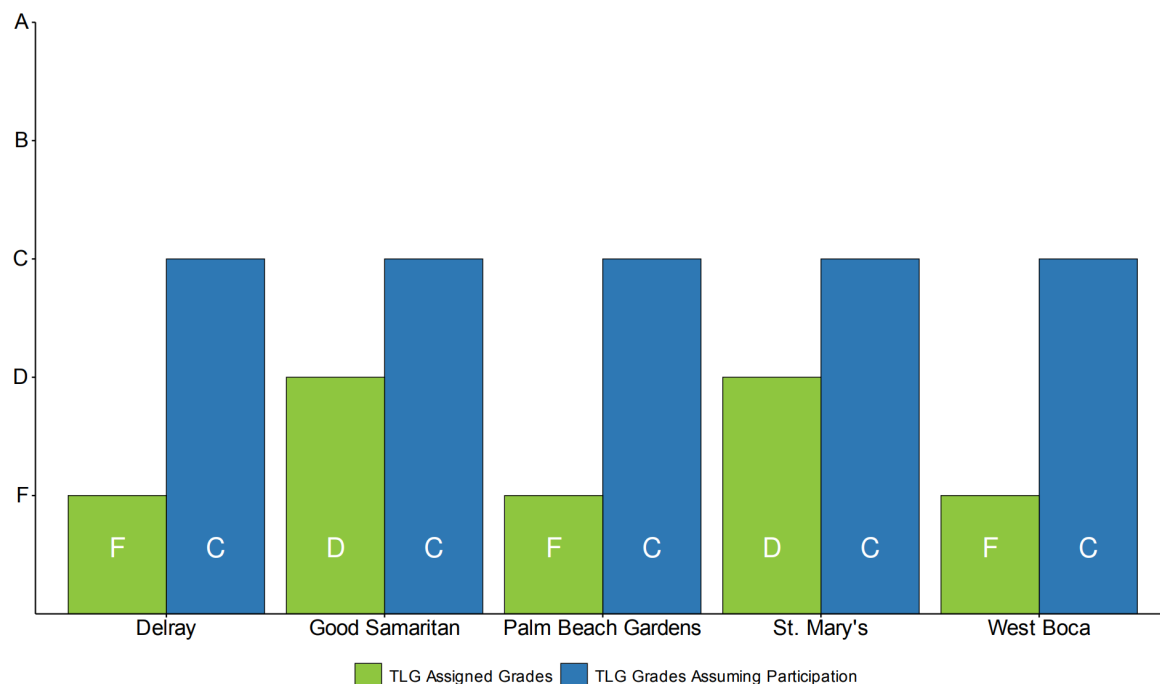
Exhibit 5
TLG's Methodology Penalizes Non-Participating Hospitals (Spring 2025)



Source: TLG Hospital Safety Grade data

Note: This figure demonstrates the impact of rescoring seven of the total 12 measures that hospitals participating in TLG's survey self-report. These seven measures are the ones that for non-participating hospitals, TLG either imputes the lowest possible value (Computerized Physician Order Entry (CPOE), Bar Code Medication Administration (BCMA), ICU Physician Staffing (IPS), Hand Hygiene) or omits in the calculation of the final grade (Safe Practice 1: Culture of Safety Leadership Structures and Systems, Safe Practice 2: Culture Measurement, Feedback, and Intervention, and Total Nursing Care Hours per Patient Day). By contrast, as shown in Exhibit 2, on each of these measures, 50% or more of participating hospitals self-report the maximum possible score. As a result, to construct the counterfactual grades that TLG would have assigned non-participating hospitals had they participated in the survey, I conservatively rescore each of the seven measures to be the average score reported by participating hospitals. This rescoring does not affect TLG's "Step 1" imputation. If TLG uses historical data to calculate a previously participating hospital's score on a given measure, this analysis does so too. TLG's "Step 1" imputation affects 38 out of 592 non-participating hospitals.

Exhibit 6
TLG's Methodology Penalizes Plaintiffs as Non-Participating Hospitals (Spring 2025)



Source: TLG Hospital Safety Grade data

Note: This figure demonstrates the impact of rescoring seven of the total 12 measures that hospitals participating in TLG's survey self-report. These seven measures are the ones that for non-participating hospitals, TLG either imputes the lowest possible value or omits in the calculation of the final grade. By contrast, as noted by Smith et al. (2017) and as shown in Exhibit 2, 50% or more of participating hospitals self-report the maximum possible value on all or nearly all such measures. As a result, to construct the counterfactual grades that TLG would have assigned Plaintiffs had they participated in the survey, I conservatively rescore each of the seven measures to be the average score reported by participating hospitals.

67. The statistics literature recommends several methods to address missing data from survey non-participants, none of which involve TLG's current method of arbitrarily imputing the lowest-possible value for non-participating hospitals.¹⁴¹ TLG has explained the rationale for this Fall 2024 change in its imputation model as follows: "[h]ospitals that decline to complete the Survey should not inadvertently benefit when compared to hospitals that demonstrate, through transparency, [that] they are on a pathway to achieve Leapfrog's high standards for patient safety."¹⁴² In other words, TLG seems to be suggesting that non-participation in its survey indicates lack of transparency, and that this lack of transparency in

¹⁴¹ TLG's imputation model is referred to as "single imputation" by statisticians. See Derrick A. Bennett, "How Can I Deal with Missing Data in My Study?" *Australian and New Zealand Journal of Public Health* 25(5) (2001): pp. 464–469 ("Bennett (2001)"), p. 465. The statistics literature supports several established approaches to single imputation such as "Last value carried forward," "Mean substitution," "Regression methods," "Hot-deck imputation," and "Cold-deck imputation." See Bennett (2001), p. 465. See also LEAPFROG00427863 – 8 at LEAPFROG00427863 ("we can't say [a score was calculated with] 'external data sources' because we're arbitrarily assigning them [hospitals that declined to report data for this measure] the points associated with the bottom scoring category ('limited achievement') or old data from the previous Survey (internal data source). Leah wanted us to make it sound like the expert panel approved it and the assigning of these points was legitimate.").

¹⁴² Final Updates to Fall 2024 TLG Scoring Methodology, pp. 2–3.

turn indicates lower hospital safety. Similarly, on its website, TLG features an interview with Ashley Tait-Dinger, Director at the Florida Alliance for Healthcare Value, in which she states that, “if a hospital or an ambulatory surgical center chooses not to participate in the hospital survey, that’s a big red flag... that they are not supportive of transparency... what is it that they’re hiding?”¹⁴³

68. Yet, I am not aware of any evidence provided by TLG to support such implied claims that lack of participation in its survey is a signal of lower hospital safety. Thus, TLG has no basis to assume that non-participating hospitals would have meaningfully lower values for these safety measures than participating hospitals.¹⁴⁴ Indeed, this assumption is contradicted by academic literature that has found in numerous settings, including the health care context, lack of survey participation is *not* an indicator of an entity lagging behind survey participants.¹⁴⁵ It is also contradicted both by Hwang et al. (2014) and Smith et al. (2017) discussed above.¹⁴⁶ Smith et al. (2017) also found no statistically significant differences between hospitals that chose to participate in TLG’s hospital survey and those that did not, in terms of several patient health outcomes measured by CMS in its Hospital Compare program.¹⁴⁷ This lack of differentiation is illustrated in Exhibit 7.

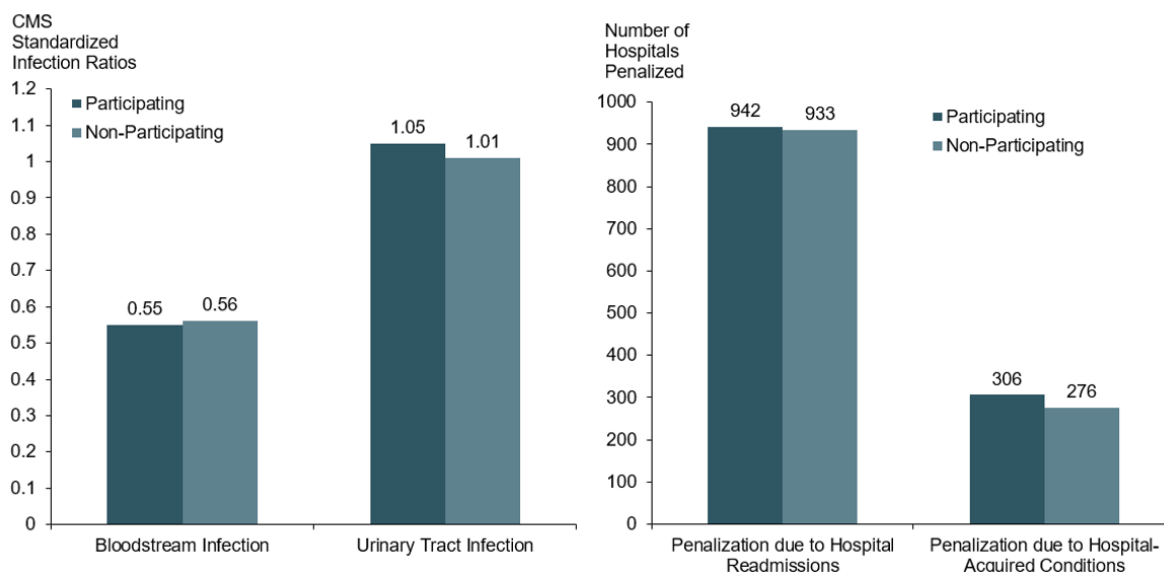
¹⁴³ “License the Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, available at <https://www.hospitalsafetygrade.org/Licensure/DataLicense>; Transcription of YouTube Video: The Leapfrog Hospital Safety Grade, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, Case No. 9:25-cv-80526, May 15, 2025, 2:10–20.

¹⁴⁴ I understand that TLG has stated that “[it] is not itself in possession of data showing Plaintiffs’ performance on the ‘imputed metrics’ considered by the methodology.” See Defendant The Leapfrog Group’s Responses to Plaintiffs’ Requests for Production, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, Case No. 9:25-CV-80526-DMM, July 1, 2025, No. 13.

¹⁴⁵ Mark Meterko et al., “Response Rates, Nonresponse Bias, and Data Quality: Results from a National Survey of Senior Healthcare Leaders,” *Public Opinion Quarterly* 79(1) (2015): pp. 130–144.

¹⁴⁶ Smith et al. (2017), p. 613; Hwang et al. (2014), p. 111.

¹⁴⁷ As noted further above, the 2017 study examined four types of patient outcomes—two outcomes related to hospital performance in terms of patient readmission rates and new patient conditions acquired during a hospital stay under the HRRP and the HACRP, and two types of infections observed among hospital patients—CLABSIs and CAUTIs. Smith et al. (2017), Table 2, pp. 1 – 2.

Exhibit 7**Hospitals That Participate in TLG's Survey Do Not Always Perform Better Than Those That Do Not**

Source: Smith et al. (2017).

Note: The left-hand panel shows SIRs obtained from CMS Hospital Compare. SIRs are risk-adjusted measures that divide the number of observed infections by the number of predicted infections calculated from: (1) Bloodstream Infection (CLABSI) and (2) Urinary Tract Infection (CAUTI) rates from a standard population. SIRs >1.0 indicate more infections observed than predicted, whereas SIRs <1.0 indicate fewer observed than predicted. The right-hand panel shows hospital penalization counts: hospitals whose HACs or readmissions during the evaluation period exceeded expected values. The right-hand panel shows: (3) Penalization due to Hospital Readmissions (i.e. penalizations under the HRRP), which could result in a penalty of up to 3% of total hospital Medicare reimbursement, and (4) Penalization due to HAC (i.e. penalizations under the HACRP), which could result in a penalty of up to 1% of total hospital Medicare reimbursement amounts. Smith et al. (2017) conducted statistical tests to examine whether there are statistically significant differences in any of these patient outcomes between participating and non-participating hospitals and found no such differences. In these data, the number of participating and non-participating hospitals were approximately the same (1098 hospitals participated and 1080 hospitals did not participate).

C. TLG's Grades Are Not Reliable Indicators of Actual Patient Health and Safety Outcomes in Hospitals

69. As discussed in Section VII, it is important for hospital ratings to serve as reliable indicators of actual patient health and safety outcomes. TLG's safety grades have been found to be severely deficient in this regard, in part by focusing more on structures and protocols rather than on actual clinical processes and patient outcomes.¹⁴⁸

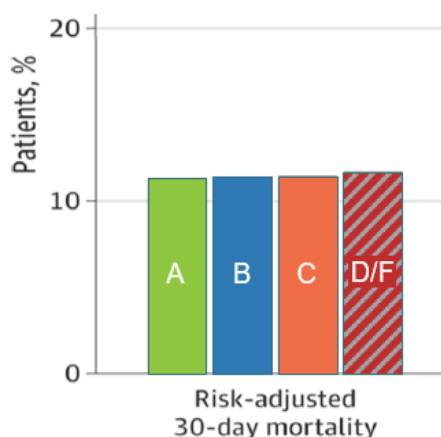
70. For instance, one study examined the extent to which TLG's grades had any association with the actual incidence of certain common infections in hospitals, such as CLABSIs, finding no statistically significant relationship.¹⁴⁹ CLABSIs are a major source of hospital-acquired infections, result in significant cost of care to hospitals, and are associated

¹⁴⁸ Smith et al. (2017), p. 606.

¹⁴⁹ Smith et al. (2017), p. 610.

with mortality rates of up to 30%.¹⁵⁰ Another study found that TLG's grades do not consistently or accurately predict the prevalence of infections that occur in rated hospitals, with "A" grade hospitals performing no better than "B" and "C" grade hospitals in terms of controlling certain infections, such as MRSA bloodstream infections.¹⁵¹ TLG's grades have also been shown to have no statistically significant relationship with other patient outcomes, such as surgical mortality or trauma outcomes.¹⁵² Yet another study found that among hospitals receiving "A," "B," or "C" grades, there were only negligible differences in patient mortality, surgical complications, and patient readmission rates.¹⁵³ Exhibit 8 and Exhibit 9 illustrate some of these findings.¹⁵⁴

Exhibit 8
Higher Graded Hospitals by TLG May Not Have Significantly Better Mortality Outcomes



Source: Gonzalez et al. (2014)

Note: Risk-adjusted 30-day mortality rates are measured for medical admissions. Gonzales et al. (2014) find no statistically significant difference in risk-adjusted 30-day mortality between hospitals receiving "A," "B," or "C" grades from TLG.

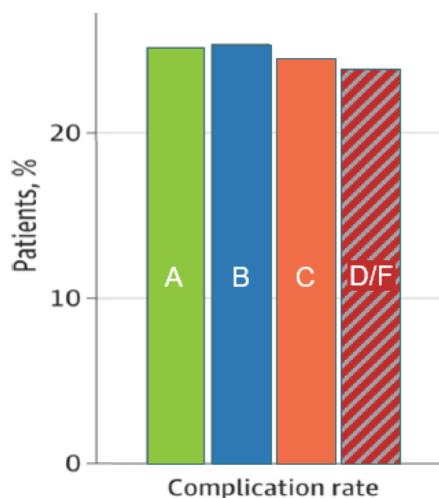
¹⁵⁰ Keyvan Rahmani et al., "Early Prediction of Central Line Associated Bloodstream Infection Using Machine Learning," *American Journal of Infection Control* 50(4) (2022): pp. 440–445.

¹⁵¹ Amy L. Pakyz et al., "Leapfrog Hospital Safety Score, Magnet Designation, and Healthcare-Associated Infections in United States Hospitals," *Journal of Patient Safety* 17(6) (2021): pp. 445–450.

¹⁵² Smith et al. (2017).

¹⁵³ Andrew A. Gonzalez and Amir A. Ghaferi, "Hospital Safety Scores: Do Grades Really Matter?" *JAMA Surgery* 149(5) (2014): pp. 413–414 ("Gonzalez et al. (2014)"), p. 2.

¹⁵⁴ The evidence from academic studies presented in this section is also corroborated by my own analysis. Using data produced by TLG in this matter and data gathered from CMS, I conducted statistical tests comparing how differently graded hospitals performed on average on each of TLG's 10 outcome measures reported in Spring 2025. This analysis indicates that for many of these outcome measures, there are no statistically significant differences between hospitals assigned different safety grades by TLG. Specifically, when comparing the average outcomes for "B" grade hospitals to "C" grade hospitals, the difference is not statistically significant for 5 of the 10 outcome measures (CAUTI, SSI: Colon, MRSA, Air Embolism, and Foreign Object Retained). Similarly, when comparing the average outcomes for "C" grade hospitals to "D/F" grade hospitals, the difference is not statistically significant for 4 of the 10 measures (SSI: Colon, PSI 04, Air Embolism, and Foreign Object Retained). This analysis again demonstrates that TLG's grades are not always reliable indicators of actual patient health and safety outcomes. Workpaper 8.

Exhibit 9***Higher Graded Hospitals by TLG May Have Higher Surgical Complication Rates***

Source: Gonzalez et al. (2014); “After Surgery: Discomforts and Complications,” Johns Hopkins Medicine, <https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/after-surgery-discomforts-and-complications>.

Note: Surgical complications may refer to a number of different negative patient outcomes experienced during surgery including shock, bleeding, wound infection, deep vein thrombosis, pulmonary embolism, lung problems, urinary retention, and reaction to anesthesia.

71. Taken together, these findings indicate that TLG’s safety grades are not reliable predictors of actual patient outcomes. One explanation for this lack of predictive power might be the methodological flaws in the measures underlying TLG’s safety grades, which I have noted in Sections X.A and B above. Regardless of the explanation, the empirical evidence that better safety grades given by TLG to some hospitals are not always associated with better health outcomes experienced by patients in those hospitals demonstrates that TLG’s safety grades fail to achieve their stated purpose of “educat[ing] consumers and purchasers about the safety and quality of healthcare facilities in their community so they can choose the best place for their care.”¹⁵⁵

Executed this 7th day of August, 2025

Sean Nicholson

¹⁵⁵ TLG How Our Ratings Are Used.

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Education

Ph.D. in economics, University of Wisconsin-Madison, 1997.
A.B. in economics, Dartmouth College, magna cum laude, 1986.

Employment

Professor, Department of Economics, Cornell University, 2021 - present.
Professor, Brooks School of Public Policy, Cornell University, 2021 – present.
Associate Center Director, Cornell Health Policy Center, 2024.
Director, Sloan Program in Health Administration, Cornell University, 2015 – 2024.
Professor, Department of Policy Analysis and Management, Cornell University, 2011 - 2021.
Associate Professor, Department of Policy Analysis and Management, Cornell University, 2006 - 2011.
Assistant Professor, Department of Policy Analysis and Management, Cornell University, 2004 - 2006.
Assistant Professor, Health Care Systems, The Wharton School, University of Pennsylvania, 1997 - 2004.
Worcester Academy, Worcester, MA, 1990 – 1992 (math teacher, cross country and track coach).
APM, Inc., New York, NY and Boston, MA (management consulting), 1986 – 1990.

Affiliations

Research Associate, National Bureau of Economic Research, 2009 – present (previously Faculty Research Fellow, 2002 – 2009). Health care group and entrepreneurship working group.
Research Director, Upstate Health Research Network, 2010-2013.
Associate Editor, *Health Economics*, 2013.
Research Fellow at VIVE, The Danish National Centre for Social Research, 2012-2020.
Advisory Committee, Institute for the Advancement of Economics at Cornell, 2010-2012.
Editorial Advisory Board, *Biotechnology HealthCare*, 2003-2013.
Senior fellow, Leonard Davis Institute, University of Pennsylvania, 1997 - 2011.
Research Associate, Population Studies Center, University of Pennsylvania, 1998 - 2004.
Visiting Scholar, National Board of Medical Examiners, 1999-2000.

Honors and Awards

Weiss Presidential Fellow, Cornell University, 2016.
SUNY Excellence in Teaching Award, 2009.
Helen Kardon Moss Anvil Award, Wharton, University of Pennsylvania, 2004.
Teaching excellence award, Worcester Academy, 1992.
Phi Beta Kappa, Dartmouth College, 1986.

Publications

Jungbauer, Thomas, Sean Nicholson, June Pan, Michael Waldman, and Lucy Xiaolu Wang, 2025, "The Organization of Innovation: Incomplete Contracts and the Outsourcing Decision," forthcoming, *American Economic Journal: Microeconomics*. NBER working paper 28379.

Braun, Robert Tyler, Sean Nicholson, Michael Richards, Derek Lake, Rahul Fernandez, Brendan O'Connell, and Larry Casalino, 2025, "The Impact of Health Insurer Acquisitions of Physician Practices on Prices and Patient Visits," *Health Services Research*, forthcoming.

Stankaitis, Joseph, Samyukta Singh, and Sean Nicholson, 2025, "Assessing Healthcare Disparities Using a Health Plan Quality Measures Index," *American Journal of Managed Care*, forthcoming (September 2025 issue).

Zhang, Yongkang, Atul Gupta, Sean Nicholson, and Jing Li, 2023, "Elevated End-of-Life Spending: A New Measure of Potentially Wasteful Spending at End of Life," *Health Services Research*, 58(1): 186-194.

Subramanian, Kritika, Juana Martinez, Joseph R. Osborne, Sean Nicholson, Jessica Van Parys, Parmanand Singh, Anjile An, Rachel Heise, Tamara Al-Hakim, Mindy Buchanan, and Trisha Youn, 2023, "Complex implementation factors demonstrated when evaluating cost-effectiveness and monitoring racial disparities associated with [18F]DCFPyL PET/CT in Prostate Cancer men," *Clinical Imaging*, 94 (February): 50-55.

Subramanian, Kritika, Juana Martinez, Sandra Huicochea Castellanos, Jana Ivanidze, Himanshu Nagar, Sean Nicholson, Trisha Youn, Jones T. Nauseef, Scott Tagawa, and Joseph R. Osborne, 2023, "Access to Cardiac PET/CT by Sarcoidosis Patients and Cost-Effectiveness Analysis of Cardiac PET/MR Compared to the Standard of Care," *Scientific Reports*.

Lucarelli, Claudio, Sean Nicholson, and Nicholas Tilipman, 2022, "Price Indices and the Value of Innovation with Heterogenous Patients," *Journal of Health Economics*, 84(July).

Bao, Yuhua, Hao Zhang, Katherine Wen, Phyllis Johnson, Philip J. Jeng, Lisa R Witkin, Sean Nicholson, M. Carrington Reid, and Bruce R. Schackman, 2021, "Robust Prescription Monitoring Programs and Abrupt Discontinuation of Long-term Opioid Use," *American Journal of Preventive Medicine*, 61(4): 537-544.

Epstein, Jordan, Sean Nicholson, Lucy Wang, Katherine Hempstead, and Sam Asin, 2020, "The Secret Menu in Health Care: A Cash Market for Imaging in California," *INQUIRY*, 57:1-8.

Asch, David A., Justin Grischkan, and Sean Nicholson, 2020, "Managing the Cost, Price, and Debt of Medical Education," *New England Journal of Medicine*, 383: 6-9.

Asch, David A., Sean Nicholson, and Marc L. Berger, 2019, "Toward Facilitated Self-Service in Health Care," *New England Journal of Medicine* 380(20) 1891-1893.

Asch, David A., Sean Nicholson, and Marc L. Berger, 2019, "How Bots Will Change the Doctor-Patient Relationship," *Harvard Business Review*, June 4, 2019.

Weatherall, Cecilie D., Anne T. Hansen, and Sean Nicholson, 2019, "The Effect of Assigning Dedicated

General Practitioners to Nursing Homes,” *Health Services Research* 54(3): 547-554.

Jindal, Rupinder P., Dinesh K. Gauri, Gaganjot Singh, and Sean Nicholson, 2018, “Factors Influencing Hospital Readmission Penalties: Are They Really Under Hospitals' Control?” *Decision Support Systems*, 110: 58-70.

Song, Minjae, Sean Nicholson, and Claudio Lucarelli, 2017, “Mergers with Inter-Firm Bundling: a Case of Pharmaceutical Cocktails,” *RAND Journal of Economics* 48(3): 810 – 834.

Epstein, Andrew J., Sean Nicholson, David A. Asch, 2016, “The Production of and Market for New Physicians’ Skill,” *American Journal of Health Economics* 2(1): 41-66.

Lakdawalla, Darius, Jason Shafrin, Claudio Lucarelli, Sean Nicholson, Zeba Khan, and Tomas Philipson, 2015, “Quality-Adjusted Cost of Care: a Meaningful Way to Measure Innovation Cost Growth Versus the Value of Health Gains,” *Health Affairs* 34(4): 555-561.

Nicholson, Sean, Marko Vujicic, Tanya Wanchek, Anthony Ziebert, and Adriana Menezes, 2015, “The Impact of Educational Debt on Dentists’ Career Decisions,” *Journal of the American Dental Association* 146(11): 800-807.

David, Guy, Henry Bergquist, and Sean Nicholson, 2014, “Income Gap across Physician Specialties in the USA.” In: Anthony Culyer (ed.), *Encyclopedia of Health Economics*, Vol 2. San Diego: Elsevier, pages 15-21.

Asch, David A., Sean Nicholson, Sindhu K. Srinivas, Jeph Herrin, and Andrew J. Epstein, 2014, “How Do You Deliver a Good Obstetrician? Outcome-Based Evaluation of Medical Education,” *Academic Medicine* 89(1): 1-3.

Wanchek, Tanya, Sean Nicholson, Marko Vujicic, Adriana Menezes, and Anthony Ziebert, 2014, “Educational Debt and Intended Employment among Dental School Seniors,” *Journal of the American Dental Association* 145(5):428-434.

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Asch, David A., Sean Nicholson, and Marko Vujicic, 2013, “Are We in a Medical Education Bubble Market,” *New England Journal of Medicine* 369(21): 1973 - 1975.

Epstein, Andrew J., Sindhu K. Srinivas, Sean Nicholson, Jeph Herrin, David A. Asch, 2013, “Association between Physician Experience after Training and Maternal Obstetrical Outcomes: Cohort Study,” *BMJ* 346: f1596.

Coyne, Karin S., Alan Wein, Sean Nicholson, Marion Kvasz, Chieh-I Chen, and Ian Milsom, 2013, “Comorbidities and Personal Burden of Urgency Urinary Incontinence: A Systematic Review,” *International Journal of Clinical Practice* 67(10): 1015-1033.

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Danzon, Patricia M., and Sean Nicholson, editors, 2012. The Oxford Handbook of the Economics of the Biopharmaceutical Industry. Oxford University Press.

Nicholson, Sean, 2012, "Financing Research and Development," in The Oxford Handbook of the Economics of the Biopharmaceutical Industry, edited by Patricia M. Danzon and Sean Nicholson. Oxford University Press.

Nicholson, Sean, Matthew Sweeney, Jennifer Whiteley, and James Harnett, 2012, "Is There a Business Case for Reducing Employees' Antidepressant Prescription Drug Cost Sharing?" *Journal of Health and Productivity* 6(1):14-22.

Nicholson, Sean, 2012, "Research Opportunities of a New Private Health Insurance Claims Data Set," *Health Management, Policy and Innovation* 1(1): 37-41.

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Dorsey Ray E., Sean Nicholson, William H. Frist, 2011, "Improving the Supply and Distribution of Primary Care Physicians," *Academic Medicine* 86:541-5433.

Epstein, Andrew, Jonathan Ketcham, and Sean Nicholson, 2010, "Specialization and Matching in Professional Services Firms," *RAND Journal of Economics* 41(4): 812-835.

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Pauly, Mark V., Sean Nicholson, Daniel Polsky, Marc L. Berger, and Claire Sharda, 2008, "Valuing Reductions in On-the-Job Illness: 'Presenteeism' from Managerial and Economic Perspectives," *Health Economics* 17(4): 469-485.

Waldman, Michael, Sean Nicholson, Nodir Adilov, and John Williams, 2008, "Autism Prevalence and Precipitation Rates in California, Oregon, and Washington Counties," *Journal of Pediatrics and Adolescent Medicine* 162(11): 1026-1034.

Nicholson, Sean, Mark V. Pauly, Anita Ya Jung Wu, James F. Murray, Steven M. Teutsch, and Marc Berger, 2008, "Getting Real Performance Out of Pay-for-Performance," *The Milbank Quarterly* 86(3): 435-457.

Nicholson, Sean, 2008, "Medical Career Choices and Rates of Return," in Frank A. Sloan and Hirschel Kasper, editors, *Incentives and Choice in Health and Health Care*. Cambridge, MA: MIT Press.

Loeppke, Ron, Sean Nicholson, Michael Taitel, Matthew Sweeney, Vince Haufle, and Ronald C. Kessler, 2008, "The Impact of an Integrated Population Health Enhancement and Disease Management Program on Employee Health Risk, Health Conditions, and Productivity," *Population Health Management* 11(6): 287-296.

Asch, David A., Andrew Epstein, and Sean Nicholson, 2007, "Evaluating Medical Training Programs by the Quality of Care Delivered by Their Alumni," *Journal of the American Medical Association* 289(9): 1049-1051.

Danzon, Patricia M., Andrew Epstein, and Sean Nicholson, 2007, "Mergers and Acquisitions in the Pharmaceutical and Biotech Industries," *Managerial and Decision Economics* 28: 307-328.

Nicholson, Sean, Mark V. Pauly, Daniel Polsky, Claire Sharda, Helena Szrek, and Marc L., Berger, 2006, "Measuring the Effects of Workloss on Productivity With Team Production," *Health Economics* 15(2): 111-123.

Nicholson, Sean, 2006, "The Effect of Cost Sharing on Employees With Diabetes," *The American Journal of Managed Care* December: SP20-SP26.

Murray, James F., Sean Nicholson, Mark Pauly, and Marc Berger, 2006, "Investing in Health to Boost Employee Productivity: The Employer's Perspective," in Ronald C. Kessler and Paul E. Stang, editors, *Health & Work Productivity: Making the Business Case for Quality Health Care*, pages 185-206.

Arcidiacono, Peter and Sean Nicholson, 2005, "Peer Effects in Medical Schools," *Journal of Public Economics* 89(2): 327-350.

Nicholson, Sean, Patricia M. Danzon, and Jeffrey McCullough, 2005, "Biotech-Pharmaceutical Alliances as a Signal of Asset and Firm Quality," *Journal of Business* 78(4): 1433-1464.

Nicholson, Sean, 2005, "How Much Do Medical Students Know About Physician Income?" *Journal of Human Resources* 40(1): 100-114.

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Polsky, Daniel, Rebecca Stein, Sean Nicholson, and M. Kate Bundorf, 2005, "Employer Health Insurance Offerings and Employee Enrollment Decisions," *Health Services Research* 40(5): 1259-1278.

Nicholson, Sean, Mark V. Pauly, Daniel Polsky, Catherine Baase, Gary M. Bilotti, Ronald J. Ozminkowski, Marc L. Berger, and Claire Sharda, 2005, "How to Present the Business Case for Healthcare Quality to Employers," *Applied Health Economics and Health Policy* 4(4): 209-218.

Burns, Lawton R., Sean Nicholson, and John Evans, 2005, "Mergers, Acquisitions, and the Advantages of Scale in the Pharmaceutical Sector." In Burns, Lawton R., ed., The Business of Healthcare Innovation. Cambridge, UK: Cambridge University Press. Pages 223-268.

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Collins, James J., Catherine M. Baase, Claire E. Sharda, Ronald J. Ozminkowski, Sean Nicholson, Gary M. Billotti, Robin S. Turpin, Michael Olson, and Marc L. Berger, 2005, "The Assessment of Chronic Health Conditions on Work Performance, Absence, and Total Economic Impact for Employers," *Journal of Occupational and Environmental Medicine* 47(6): 547-557.

Nicholson, Sean and Barbara Wolfe, 2005, "Public Policy and Health Care Expenditures," in Lee-Jay Cho, Hyungpyo Moon, Yoon Hyung Kim, Sang-Hyop Lee, editors, *A New Paradigm for Social Welfare in the New Millenium*. Seoul, Korea: Korea Development Institute Press. Pages 265-290.

Polsky, Daniel, and Sean Nicholson, 2004, "Why Are Managed Care Plans Less Expensive: Risk Selection, Utilization, or Reimbursement?" *Journal of Risk and Insurance* 71(1): 21-40.

Nicholson, Sean, Daniel Polsky, Kate Bundorf, and Rebecca Stein, 2004, "The Magnitude and Nature of Risk Selection in Employer-Sponsored Health Plans," *Health Services Research* 39(6) Part 1: 1817-1838.

Turpin, Robin S., Ronald J. Ozminkowski, Claire E. Sharda, James J. Collins, Marc L. Berger, Gary M. Billotti, Catherine M. Baase, Michael J. Olson, and Sean Nicholson, 2004, "Reliability and Validity of the Stanford Presenteeism Scale," *Journal of Occupational and Environmental Medicine* 46(11): 1123-1133.

Berger, Marc L., Robert A. Howell, Sean Nicholson, and Claire E. Sharda, 2003, "Investing in Healthy Human Capital," *Journal of Occupational and Environmental Medicine* 45(12): 1213-1225.

Nicholson, Sean, 2002, "Physician Specialty Choice Under Uncertainty," *Journal of Labor Economics* 20(4): 816-847.

Pauly, Mark V., Sean Nicholson, Judy Xu, Dan Polsky, Patricia Danzon, James F. Murray, and Marc L. Berger, 2002, "A New General Model of the Impact of Absenteeism on Employers and Employees,"

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Nicholson, Sean. *Medicare Hospital Subsidies: Money in Search of a Purpose*. Washington, D.C.: American Enterprise Institute Press, May 2002.

Nicholson, Sean and David Song, 2001, "The Incentive Effects of the Medicare Indirect Medical Education Policy," *Journal of Health Economics* 20(6): 909-933.

Nicholson, Sean, Mark V. Pauly, Lawton R. Burns, Agnieszka Baumritter, and David A. Asch, 2000, "Measuring Community Benefits Provided by For-Profit and Nonprofit Hospitals," *Health Affairs* November/December: 168-177.

Pauly, Mark V. and Sean Nicholson, 1999, "The Managed Care Backlash: Adverse Consequences of Adverse Selection," *Journal of Health Politics, Policy and Law* 24(5): 921-930.

Kreider, Brent and Sean Nicholson, 1997, "Health Insurance and the Homeless," *Health Economics* 6(1): 31-41.

Non-Refereed Op Ed Articles

Asch, David. A, Justin Grischkan, and Sean Nicholson, "Lower the Cost of Producing Doctors, Not Just the Price of Going to Medical School," *STAT*, July 21, 2020.

Nicholson, Sean, and David A. Asch, "Hospitals Need Cash. Health Insurers Have It," *Harvard Business Review*, March 25, 2020.

Working Papers

Braun, Robert Tyler, Sean Nicholson, Michael Richards, Derek Lake, Rahul Fernandez, Brendan O'Connell, and Larry Casalino, 2025, "Evidence of Optum's ASC Pricing Power and Provider Selection," under review.

Stankaitis, Joseph, Han Pham, Samyukta Singh, and Sean Nicholson, 2025, "Assessing New York's Health Disparities Using Health Plan Quality Data," revised and resubmitted to *American Journal of Managed Care*.

Braun, Robert Tyler, Sean Nicholson, Michael Richards, Derek Lake, Rahul Fernandez, Brendan O'Connell, and Larry Casalino, 2024, "Association of Optum Ownership of Physician Practices with Medicare Advantage Risk Scores."

Nicholson, Sean, Michael Waldman, and Robin Wang, 2024, "Autism Diagnosis Rates and Precipitation: Evidence from the United Kingdom, 1995-2013."

Nicholson, Sean, Stephenson Strobel, and Xingqi Ye, 2024, "Access, Health and Wealth: The Short and Long Run Effects of the Saskatchewan Municipal Doctors Scheme on Rural Access to Physicians, Health Improvements, and Economic Well-being."

Research Grants

Principal Investigator, Gilead Sciences, The Business Impact of Environmental, Social, and Governance (ESG) Programs and Policies in the Pharmaceutical Industry.

Co-investigator, Cornell University Cross Campus Health Policy Seed Grant, Implications of PBM Consolidation on Pharmaceutical Access and Related Disparities. Pragya Kakani, Principal Investigator. Award: \$20,000.

Co-investigator, Cornell University Cross Campus Health Policy Seed Grant, The Effect of Medicaid Expansion on Pharmacy Availability in Disproportionately Black and Hispanic Neighborhoods. Pragya Kakani, Principal Investigator. Award: \$15,000.

Co-investigator, Laura & John Arnold Foundation, The Impact of Health Insurer Acquisition of Physician Practices and Ambulatory Surgery Centers on Commercial Prices and Spending. Award: \$82,000 (9/2022 – 3/2024).

Co-investigator, Substance Abuse and Mental Health Services Administration, Addressing Buffalo's Opioid Epidemic with Medication-Assisted Treatment. Joseph Stankaitis, Principal Investigator. Award: \$523,000 (9/2018 – 9/2021).

Co-investigator, Agency for Healthcare Research and Review, The Medicaid Fee Bump: Increased Reimbursements to Primary Care Providers and Health Care Utilization Among Dual-Eligibles with Chronic Conditions. Mark Unruh, Principal Investigator. Award: \$78,000 (9/2017 – 9/2020).

Co-Investigator, Robert Wood Johnson Foundation, 73185, Exploring Cash Markets for Health Care and Related Policy Changes Needed to Enable a Consumer-Oriented, Value-Based Health System. Jordan Epstein, Principal Investigator. Award: \$120,000 (1/2016 – 10/2016).

Co-Investigator, Agency for Healthcare Research & Quality, R01HS022306, Relative Price, Payer Mix and Regional Variations in Medical Care. Jonathan D. Ketcham, Principal Investigator. Award: \$282,000 (2013 – 2014).

Principal Investigator, FAIR Health (subcontract from Syracuse University), Developing a New Method to Determine Out-of-Network Payments. Award: \$410,000 (1/11 – 12/13).

Principal Investigator, gift from Larry Stern, Is the Additional Money the U.S. Spends on Medical Care Relative to Europe Worth It? Award: \$100,000 (1/12 – 12/13).

Principal Investigator, FAIR Health (subcontract from Syracuse University), Developing a New Method to Determine Out-of-Network Payments. Award: \$50,000 (8/10 – 12/10).

Principal Investigator, Pfizer, A Quality-adjusted Price Index for Lung and Breast Cancer Drugs. Award: \$82,000 (3/08 – 12/08).

Investigator, National Board of Medical Examiners, Clinical Outcome-Based Assessment of Medical Education: Concept and Evaluation. David A. Asch, Principal Investigator. Award: \$150,000 (7/07 – 6/08).

Principal Investigator, Pfizer, Johnson & Johnson, and AstraZeneca, A Quality-adjusted Price Index for Colon Cancer Drugs: 1993-2005. Award: \$72,000 (8/06 – 12/07).

Principal Investigator, Merck & Co., Inc., The Impact of Pay-for-Performance Programs on Health Outcomes and the Delivery of Medical Care. Award: \$25,000 (12/05 – 10/06).

Principal Investigator, Integrated Benefits Institute, The Cost of Absences in the Retail Sales Industry, Award: \$5,000 (12/05 – 8/06).

Investigator, Robert Wood Johnson Foundation, Costs and Benefits of Physician Interaction with Health Plans. Lawrence Casalino, Principal Investigator. Award: \$101,000 (9/05 – 8/06).

Principal Investigator, Merck Company Foundation, A Quality-adjusted Price Index for Cancer Drugs. Award: \$35,000 (1/05 – 12/06).

Principal Investigator, Centers for Disease Control and Prevention, A New Method of Valuing Investments in Workers' Health. R01 CD000011-01. Award: \$725,000 direct costs (9/04 – 9/07).

Principal Investigator, Cornell University, Determinants of Physician and Hospital Adoption of New Medical Technologies. Award: \$30,000 (3/05-3/08).

Co-principal investigator, Mack Center for Technological Innovation, University of Pennsylvania, Incentives to Innovate in the Biotechnology and Pharmaceutical Industries. Andrew Metrick, Principal Investigator. Award: \$14,000 (7/04 – 6/05).

Principal Investigator, The Research Foundation, University of Pennsylvania, Incentives to Innovate in the Biotechnology and Pharmaceutical Industries. Award: \$16,000 (2/04 – 6/05).

Principal Investigator, U.S. Department of Agriculture. Determinants of Physicians' Treatment Choices. Award: \$5,000 (7/04 – 6/05).

Wharton Program on Pharmaceutical Policy, Economics and Management, Merck & Company Foundation. Patricia Danzon, Principal Investigator. Award: \$1,090,910 (1/00-12/05).

Principal Investigator, The Leonard Davis Institute of Health Economics, University of Pennsylvania. Physician Learning, Information Diffusion, and Best Practice Adoption. Award: \$10,000 (7/02 - 6/03).

Developing and Validating a Measure of the Impact of Absenteeism and Reduced Presenteeism on Worker and Team Productivity. Merck & Company. Mark V. Pauly, Principal Investigator. Award: \$171,000 (7/02 - 6/03).

Principal Investigator, The Research Foundation, University of Pennsylvania. The Impact of Managed Care on the Delivery of Medical Care. Award: \$12,000 (7/01 – 6/02).

Health Plan Choices and Adverse Selection in Employer-Sponsored Health Insurance. Robert Wood Johnson Foundation. Daniel Polsky, Principal Investigator. Award: \$125,000 (2/02 – 7/03).

Current and Potential Labor Shortages in Child Neurology. Child Neurology Society. Daniel Polsky, Principal Investigator. Award: \$100,000 (10/01 – 9/02).

Evolution of HMOs and Risk Selection. The Robert Wood Johnson Foundation. Daniel Polsky, Principal Investigator. Award: \$100,000 (2/99 - 1/00).

Principal Investigator, The Research Foundation, University of Pennsylvania. Determinants and Accuracy of Income Expectations. Award: \$21,000 (7/98 - 6/99).

Principal Investigator, Population Studies Center, University of Pennsylvania. Government Reimbursement of Medicare HMOs. Award: \$19,000 (7/99 - 6/00).

Provision of Community Benefits Among the Federation of American Hospital Systems□ Member Hospitals. Federation of American Hospital Systems. Mark V. Pauly, Principal Investigator. Award: \$77,000 (1/99 - 9/99).

Measuring the Effects of Health-improving Employee Benefits on Employer Profits and Productivity. Merck & Company. Mark V. Pauly, Principal Investigator. Award: \$140,000 (9/99 - 12/00).

Department of Health and Human Services, Bureau of Health Professions. Health Administration Trainingships and Special Projects. Mark V. Pauly, Principal Investigator. Award: \$146,000 (1/97 - 6/02).

Co-principal investigator, Huntsman Emerging Technologies Program. Determinants of R&D Success in Biotech and Pharmaceuticals. Award: \$14,000.

Co-principal investigator. Merck & Company. Determinants of R&D Success in Biotech and Pharmaceuticals. Award: \$10,000.

Co-principal investigator, Huntsman Emerging Technologies Program. Efficiency in the Market for Biotech-Pharmaceutical Deals. Award: \$14,000.

External Presentations

“Elevated End-of-Life Spending: A New Measure of Potentially Wasteful Spending at End of Life,” University of Georgia (December 2022).

“Quality-Adjusted Prescription Drug Price Indexes,” Ireland Health Economics Masterclass, Dublin, Ireland (March 2022).

“Price Indices and the Value of Innovation When Preferences are Heterogeneous,” Hoover Institution, Stanford University (remote) (June 2020).

“A Cash Market for Imaging in California,” American Society of Health Economists conference, Philadelphia, PA (June 2016).

“Relative Prices, Payer Mix and Regional Variations in Medical Care,” University of North Carolina (February 2019); Weill Medical College (May 2018); Indiana University (October 2017); University of Southern California (April 2015); University of Connecticut, Storrs, CT (September 2014); The Danish National Centre for Social Research, Copenhagen, Denmark (April 2014); Vanderbilt University, Nashville, TN (March 2014); University of Pennsylvania, Philadelphia, PA (December 2013).

“Insurer and Patient Payments for Out-of-Network Physician Services,” International Health Economics Association meetings, Sydney Australia (July 2013).

“The Effect of Educational Debt on Dentists’ Career Decisions,” Weill Medical College, New York, NY (November 2013); Intelligence Fair, American Dental Association, Chicago, IL (May 2013).

“Bundling Among Rivals: a Case of Pharmaceutical Cocktails,” University of Southern California, Los

Angeles, CA (December 2011).

“Supply Side Implications of Insurance Coverage Expansions: Research Insights for Policy,” Academy Health conference, Washington, D.C. (December 2011).

“The Effect of the Economy on Health and Health Related Behaviors,” University of Colorado – Denver School of Public Health, Denver, CO (January 2011); Work, Stress and Health 2011 conference, Orlando, FL (May 2011); The Danish National Centre for Social Research seminar, Copenhagen, Denmark (June 2011); International Stress Management Association international congress, Porto Alegre, Brazil (June 2012).

“What is the Value of a Healthy Worker to a Company?” keynote address at the International Stress Management Association international congress, Porto Alegre, Brazil (June 2012); keynote address at the Work, Stress and Health 2011 conference, Orlando, FL (May 2011).

“Specialization and Matching in Professional Services Firms,” Boston University/Harvard University/MIT University health economics seminar, Boston, MA (March 2010); University of Connecticut School of Business, Storrs, CT (April 2010).

“What Does the U.S. Buy and What Does It Get From Its Cancer Chemotherapy Purchases Compared to European Nations?” University of Porto Business School, Porto, Portugal (March 2010); American Society of Health Economics conference, Ithaca, NY (June 2010); Academy Health, Boston, MA (June 2010).

“Medical Workforce,” Harvard University, Handbook of Health Economics, Volume 2 conference, Cambridge, MA (October 2010).

“Financing Research and Development,” conference on the Economics of the Biopharmaceutical Industry, The Wharton School (November 2009).

“A Quality-Adjusted Price Index for Colorectal Cancer Drugs,” Health Economics Interest Group, Academy Health, Orlando, Florida (June 2007); Ad Hoc Pharmaceutical Group, New York City (October 2007); Pharmaceutical Economics and Policy Council, Rome, Italy (November 2007); Duke University (April 2008); University of Chicago (May 2008); Missoula Tumor Board, Missoula, MT (July 2008); National Bureau of Economic Research (November 2008); Bureau of Economics Analysis, Washington, D.C. (September 2011); Value of Innovation in Cancer Care conference, Princeton, NJ (November 2011).

“Medical Career Choices and Rates of Return,” Council of Graduate Medical Education, Rockville, MD (May 2008).

“A Simple Measurement Tool to Measure a Company’s Absenteeism and Presenteeism Costs,” The Conference Board: The Wellness Advantage, Boca Raton, FL (December 2008).

“Valuing Reductions in On-the-Job Illness: ‘Presenteeism’ From Managerial and Economic Perspectives,” International Health Economics Association conference, Copenhagen, Denmark (July 2007).

“Is Early Childhood Television Watching an Environmental Cause of Autism?” NBER Health Care Meeting, Cambridge, MA (October 2006); Yale School of Public Health, New Haven, CT (September 2007); Penn State University (October 2007); Federal Trade Commission (October 2007).

“Does Financing Have a Real Effect on Drug Development?” RAND Corporation, Los Angeles, California (September 2006); University of Illinois-Chicago, Chicago, IL (October 2006); ASHE conference, Madison, WI (June 2006); Pharmaceutical Economics and Policy Council, Chicago, IL (January 2007); BIO Conference, Boston, MA (May 2007).

“Specialization and Sorting in the Obstetrics Market?” NBER Health Care Meeting (May 2006); Syracuse University (October 2005); University of Chicago (January 2005).

“A New Method of Valuing Investments in Workers’ Health,” IBI/NBGH Joint Forum on Health, Productivity, and Absence Management, Washington, D.C. (November 2006); IBI Research Meeting, Philadelphia, PA (April 2007); Centers for Disease Control and Prevention, Atlanta (April 2006); Investment Forum Foundation meeting, Washington, D.C. (March 2006).

“Incentives to Innovate in the Biotech and Pharmaceutical Industries,” International Health Economics Association conference, Barcelona, Spain (July 2005).

“How to Quantify the Financial Value of Improvements in Workers’ Health?,” International Health Economics Association conference, Barcelona, Spain (July 2005); Centers for Disease Control and Prevention, Atlanta (April 2005); Consumers, Information and the Evolving Healthcare Marketplace conference, Cornell University (April 2005).

“Mergers and Acquisitions in the Pharmaceutical and Biotech Industries”: Pharmaceutical Economics and Policy Council (January 2005); Federal Trade Commission (March 2004); Lehigh University (November 2003); University of Rochester (October 2003).

“Physician Learning and Best Practice Adoption: An Application to Cesarean Sections”: Weill Cornell Medical Center, New York, NY (March 2006); American Economics Association annual meeting (January 2004); Medical University of South Carolina (January 2004); Cornell University (January 2004); Columbia University/NYU/CUNY seminar (September 2003); NBER Summer Institute (July 2003); International Health Economics Association meeting (June 2003); 14th Annual Health Economics Conference (April 2003); Brigham Young University (February 2003); Dartmouth College (October 2002).

“Barriers to Entering Medical Specialties”: Federal Trade Commission (April 2004); Yale University (October 2003); Brigham Young University (February 2003); International Health Economics Association meetings (July 2001).

“Peer Effects in Medical School”: Stanford University (February 2002); University of Wisconsin-Madison (November 2001); College of William and Mary (September 2001); 12th Annual Health Economics Conference (June 2000); National Board of Medical Examiners (June 2000).

“Biotech-Pharmaceutical Alliances as a Signal of Asset and Firm Quality”: Northwestern University (February 2002); Program on Pharmaceutical Policy Issues Research Conference, University of Siena, Italy (February 2002).

“Physician Income Prediction Errors: Sources and Implications for Behavior,” University of Chicago (February 2002); Stanford University (February 2002); University of California-Berkeley (February 2002).

“The Magnitude and Nature of Risk Selection in Employer-Sponsored Health Plans”: University of California, Irvine (June 2003); International Health Economics Association meeting (June 2003); 8th

Northeast Regional Health Economics Research Symposium (August 2002); University of Wisconsin-Madison (November 2001); Johns Hopkins School of Hygiene and Public Health (May 2001).

“Physician Income Expectations and Specialty Choice”: Survey Research on Household Expectations and Preferences, University of Michigan (November 2001); Iowa State University (November 2001); Duke University (November 1999); International Health Economics Association meetings (June 1999).

“Developing and Validating a Measure of the Impact of Absenteeism and Reduced Presenteeism on Worker and Team Productivity,” International Health Economics Association meetings (June 2003).

“The Effect of Patient Outcomes on Physicians’ Patient Volumes, Patient Severity, and Treatment Methods,” International Health Economics Association meetings (June 2003).

“Private Sector Drug Development Alliances,” Wharton Impact Conference: Pharmaceutical Innovation in the Global Economy (October 2002).

“Personal Economics and Other Factors Influencing Specialty Selection,” Institute of Medicine Workshop on the Obstacles to the Incorporation of Research Into Psychiatry Residency Training (June 2002).

“Determinants of R&D Success: Drugs or Firms?,” Merck & Company (October 2001).

“Measuring Community Benefits Provided by For-Profit and Nonprofit Hospitals,” St. Louis Area Business Health Coalition (March 2001).

“Public Policy and Health Expenditures,” A New Paradigm for Social Welfare in the New Millennium, East-West Center (January 2001).

“The Unintended Consequences of Medicare’s Payment Policies”: American Enterprise Institute (March 1999); 6th Northeast Regional Health Economics Research Symposium (August 1998).

“Applying the RBRVS Concept to Medical Education,” American Medical Association Section on Medical Schools (December 1998).

“The Effect of Federal Policy on Hospital Care for the Poor,” 10th annual Health Economics Conference (June 1998).

Teaching

The U.S. Health Care System, PAM 2350 (undergraduate): 2008 - 2023

Health Care Organizations and Behavior, PAM 5353 (executive MHA): 2019 – 2024.

Health Care Financial Management II, PAM 5630 (masters): 2004 - 2009; 2011 - 2023.

Health Care Finance, PAM 5633 (executive MHA): 2020 - 2024.

Key Management Issues in the Biotech and Pharmaceutical Industries, PAM 5900 (executive): 2019 - 2024.

Pharmaceutical Management and Policy, PAM 3110 (undergraduate): 2012 - 2014.

Perspectives on Health Policy and Management in the U.S., PAM 2351 (undergraduate), 2020.

Health Care Financial Management, PAM 5620 (masters): 2005 - 2006.

Information Resources Management in Health Care Organizations, PAM 5641 (masters): 2007-2009; 2015-2020.

Financial Management of Health Institutions, HCMG 849 (MBA): 1998-2003.

The Economics of Health Care and Policy, HCMG 844 (Ph.D./MBA): 1997-2004.

e-Health: Business Models and Impact, HCMG 866 (MBA): 2001-2004.

The Economics of Information in the Health Care Market HCMG 900 (Ph.D.): 2002.

Financial Management of Health Institutions, HCMG 214 (undergraduates): 1999.

Service

Trustee, Atlantic Health System (Morristown, NJ), 2018 - present.

Trustee, Robert Packer Hospital, Guthrie Health System (Sayre, PA), 2009 - present.

Committee on Academic Programs & Policies, 2025 – 2028.

Member, Faculty Advisory Committee on Tenure Appointments, Cornell University, 2019 – 2021.

Chair, Faculty Committee on Program Review, Cornell University, 2017 – present (member 2017 – 2019).

School of Public Policy Planning Committee, Cornell University, 2020 – 2021.

School of Public Policy Dean Search Committee, Cornell University, 2021.

Faculty adviser, Swimming and Diving team, Cornell University, 2010 – present.

Study section reviewer, National Institutes of Health, Health Services Organization and Delivery Study Section, June 2007, February 2008, February 2010, and June 2012. NIA, fall 2017.

NSF grant reviewer: 2008 and 2009.

Study panel member, Treating the Health of the World Trade Center Rescue Workers, Centers for Disease Control and Prevention, Denver, CO, 2006.

Prior Testimony of Sean Nicholson in the Last Four Years

Trial Testimony, *The People of the State of California v. Purdue Pharma L.P., et al.*, Supreme Court of the State of California in and for the County of Orange, Case No. 30-2014-00725287-CY-BT-CXC, July 2021

Deposition, *Sandoz Inc. et al. v. United Therapeutics Corp. et al.*, United States District Court for the District of New Jersey, Case No. 3:19-cv-10170, August 2021

Deposition, *The State of Rhode Island, by and through Peter F. Neronha, Attorney General, v. Purdue Pharma L.P., et al.*, Supreme Court of the State of Rhode Island, Case No. PC2018-4555, September 2021

Deposition, *County of Dallas v. Purdue Pharma L.P., et al.*, District Court 116th Judicial District, Dallas County, Texas, Case No. 2018-77098, September 2021

Trial Testimony, *IN RE OPIOID LITIGATION: Suffolk County v. Purdue Pharma L.P., et al.*, Index No. 400001/2017, U.S. District Court for the Southern District of New York; *Nassau County v. Purdue Pharma L.P., et al.*, Index No. 400008/2017, U.S. District Court for the Southern District of New York; *The State of New York v. Purdue Pharma L.P., et al.*, Index No. 400016/2018, U.S. District Court for the Southern District of New York, November 2021

Deposition, *The State Florida, Office of the Attorney General, Department of Legal Affairs v. Purdue Pharma L.P., et al.*, Circuit Court of the Sixth Judicial Circuit In and For Pasco County, FL, Case No. 2018-CA-001438, December 2021

Deposition, *The City and County of San Francisco, California and The People of the State of California v. Purdue Pharma L.P., et al.*, U.S. District Court for the Northern District of California, Case No. 3:18-cv-07591-CRB, December 2021

Deposition, *Joseluis Gutierrez Montal, et al. v. Gilead Sciences, Inc., et al.*, Superior Court of Alameda County, RG19028249, (as to Plaintiff Shelton Stile only), in *Gilead Tenofovir Cases*, Judicial Council Coordination Proceeding (JCCP) No. 5043 (CJC-19-005043), Superior Court for the State of California, County of San Francisco, March 2022

Deposition, *The United States of America v. Gilead Sciences, Inc. and Gilead Sciences Ireland, UC*, United States Court of Federal Claims, Case No. 20-499 C, April 2022

Trial Testimony, *State of West Virginia ex rel., Patrick Morrissey, Attorney General v. Teva Pharmaceutical Industries, Ltd., et al.*, Circuit Court of Kanawha County, West Virginia, Civil Action No. 19-C-104 BNE, May 2022

Deposition, *State of New Mexico ex. rel. Hector Balderas, Attorney General vs. Purdue Pharma L.P., et al.*, New Mexico First Judicial District Court, County of Santa Fe, State of New Mexico, No. D-101-CV-2017-02541, May 2022

Deposition, *In Re: Valeant Pharmaceuticals International, Inc. Securities Litigation*, U.S. District Court for the District of New Jersey, Case No. 18-cv-00343-MASLHG, June 2022

Trial Testimony, *The City and County of San Francisco and the People of the State of California v. Purdue Pharma L.P., et al.*, United States District Court, Northern District of California, Case No. 3:18-cv-07591-CRB, June 2022

Trial Testimony, *The United States of America v. Gilead Sciences, Inc. and Gilead Sciences Ireland, UC*, United States Court of Federal Claims, Case No. 20-499 C, June/July 2022

Deposition, *In re: Insulin Pricing Litigation*, United States District Court for the District of New Jersey, Civil Action No. 17-699, August 2022

Deposition, *State of Nevada vs. McKesson Corporation, et al.*, District Court Clark County, Nevada, Case No. A-19-796755-B, January 2023

Deposition, *Mayor and City Council of Baltimore, and Government Employees Health Association v. Actelion Pharmaceuticals LTD., Actelion Pharmaceuticals US, Inc., Janssen Research & Development, LLC*, United States District Court for the District of Maryland, Case No. 1:18-cv-03560, July 2023

Deposition, *In re ACTOS Antitrust Litigation*, United States District Court, Southern District of New York, Case No. 1:13-cv-09244, February 2024

Deposition, *Mayor & City Council of Baltimore City v. Purdue Pharma L.P., et al.*, Circuit Court of Maryland for Baltimore City, Case No. 24C18000515, March 2024

Deposition, *Janssen Pharmaceuticals, Inc. v. Emergent Biosolutions, Inc., and Emergent Manufacturing Operations Baltimore, LLC*, American Arbitration Association, Case No. 01-22-9992-5304, April 2024

Trial testimony, *Sandoz Inc. et al. v. United Therapeutics Corp. et al.*, United States District Court for the District of New Jersey, Case No. 3:19-cv-10170, May 2024

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- Amy L. Pakyz et al., “Leapfrog Hospital Safety Score, Magnet Designation, and Healthcare-Associated Infections in United States Hospitals,” *Journal of Patient Safety* 17(6) (2021): pp. 445–450
- Andrew A. Gonzalez and Amir A. Ghaferi, “Hospital Safety Scores: Do Grades Really Matter?” *JAMA Surgery* 149(5) (2014): pp. 413–414
- Andrew J. Epstein et al., “Association Between Physician Experience After Training and Maternal Obstetrical Outcomes: Cohort Study,” *BMJ* 346: f1596 (2013): pp. 2–10
- Andrew J. Epstein, Sean Nicholson, David A. Asch, “The Production of and Market for New Physicians’ Skill,” *American Journal of Health Economics* 2(1) (2016): pp. 41–65
- Avedis Donabedian, “Evaluating the Quality of Medical Care,” *The Milbank Quarterly* 83(4) (2005): pp. 691–729, reprinted from *The Milbank Memorial Fund Quarterly* 44(3) (1966): pp. 166–206
- Charlotte Kelly et al., “Are Differences in Travel Time or Distance to Healthcare for Adults in Global North Countries Associated with an Impact on Health Outcomes? A Systematic Review,” *BMJ Open* (2016)
- David A. Asch et al., “Evaluating Obstetrical Residency Programs Using Patient Outcomes,” *Journal of the American Medical Association* 302(12) (2009): pp. 1277–1283
- David A. Asch et al., “How Do You Deliver a Good Obstetrician? Outcome-Based Evaluation of Medical Education,” *Academic Medicine* 89(1) (2014): pp. 24–26
- David M. Cutler et al., “The Role of Information in Medical Markets: An Analysis of Publicly Reported Outcomes in Cardiac Surgery,” *American Economic Review* 94(2) (2004): pp. 342–346
- Derrick A. Bennett, “How Can I Deal with Missing Data in My Study?” *Australian and New Zealand Journal of Public Health* 25(5) (2001): pp. 464–469
- Devin G. Pope, “Reacting to Rankings: Evidence from ‘America’s Best Hospitals,’” *Journal of Health Economics* 28 (2009): pp. 1154–1165

- Donald Berwick and Daniel M. Fox, “Evaluating the Quality of Medical Care: Donabedian’s Classic Article 50 Years Later,” *The Milbank Quarterly* 94(2) (2016): pp. 237–241
- “Emergency Ambulance Destination,” *Annals of Emergency Medicine* 34(1) (1999)
- “Emergency Department Planning and Resource Guidelines,” *Annals of Emergency Medicine* 51(5) (2008): pp. 687–695
- J. Matthew Austin et al., “Safety in Numbers: The Development of Leapfrog’s Composite Patient Safety Score for U.S. Hospitals,” *Journal of Patient Safety* 9 (2013): pp. 1–9, available at https://www.hospitalsafetygrade.org/media/file/JournalofPatientSafety_HospitalSafetyScore.pdf
- Jon Nicholl et al., “The Relationship Between Distance to Hospital and Patient Mortality in Emergencies: An Observational Study,” *Emergency Medicine Journal* 24 (2007): pp. 665–668
- Joseph Stankaitis, Samyukta Singh, and Sean Nicholson, “Addressing Health Care Disparities Using a Health Plan Quality Measures Index,” *American Journal of Managed Care* 31(9) (2025): pp. 1–19
- Judith H. Hibbard, Jean Stockard, and Martin Tusler, “Hospital Performance Reports: Impact on Quality, Market Share, And Reputation,” *Health Affairs* 24(4) (2005): pp. 1150–1160
- Karl Y. Bilimoria et al., “Rating the Raters: An Evaluation of Publicly Reported Hospital Quality Rating Systems,” *NEJM Catalyst* 5(4) (2019)
- Keyvan Rahmani et al., “Early Prediction of Central Line Associated Bloodstream Infection Using Machine Learning,” *American Journal of Infection Control* 50(4) (2022): pp. 440–445
- Marjorie A. Erdmann et al., “Transparency in Hospital Safety: A field study of ‘what it takes’ for hospitals to complete the Leapfrog Group Hospital Survey,” *Oklahoma State Medical Proceedings* 8(1) (2024): pp. 1–18
- Mark Meterko et al., “Response Rates, Nonresponse Bias, and Data Quality: Results from a National Survey of Senior Healthcare Leaders,” *Public Opinion Quarterly* 79(1) (2015): pp. 130–144
- Nisha Kurian et al., “Predicting Hospital Overall Quality Star Ratings in the USA,” *Healthcare* 9(4) (2021): pp. 1–12
- Sarah A. Ibrahim et al., “The Evidence Base for US Joint Commission Hospital Accreditation Standards: Cross Sectional Study,” *BMJ* 377:e063064 (2022)

- Shawna N. Smith et al., “Dissecting Leapfrog: How Well Do Leapfrog Safe Practices Scores Correlate with Hospital Compare Ratings and Penalties, and How Much Do They Matter?” *Medical Care* 55(6) (2017): pp. 606–614
- ShinYi Chou, Mary E. Deily and Sihui Li, “Travel Distance and Health Outcomes for Scheduled Surgery,” *Medical Care* 52(3) (2014): pp. 250–257
- Sindhu K. Srinivas et al., “Improvements in US Maternal Obstetrical Outcomes From 1992 to 2006,” *Medical Care* 48(5) (2010): pp. 487–493
- Thomas C. Buchmueller, Mireille Jacobson and Cheryl Wold, “How Far To The Hospital?: The Effect Of Hospital Closures on Access to Care,” *Journal of Health Economics* 25(4) (2006): pp. 740–761
- Wenke Hwang et al., “Hospital Patient Safety Grades May Misrepresent Hospital Performance,” *Journal of Hospital Medicine* 9(2) (2014): pp. 111–115
- Yiran Dong and Chao-Ying Joanne Peng, “Principled missing data methods for researchers,” *SpringerPlus* 2(222) (2013): pp. 1–17

Books and Book Chapters

- Jeffrey M. Wooldridge, *Introductory Econometrics, 5e*, (Mason, OH: South-Western, Cengage Learning, 2013)
- Roderick J. A. Little and Donald B. Rubin, “Single Imputation Methods,” in *Statistical Analysis with Missing Data 3e* (Hoboken, NJ: Wiley, 2020), pp. 67–84

Bates Stamped Documents

- LEAPFROG00044966
- LEAPFROG00045043
- LEAPFROG00178624
- LEAPFROG00427863
- PBHN000002071
- PBHN000002076
- PBHN000002079
- PBHN000002086
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- PBHN000002211
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- PBHN000002219

Codes and Regulations

- Fl. Code 395.1041(4)(e)
- Section 1886(b)(3)(B)(viii)(XI) of the Social Security Act

Data

- LEAPFROG00020679 (“TLG Hospital Safety Grade data”)
- CMS Hospitals Archived Data Snapshots

Expert Reports

- Expert Report of Jonah Berger, Ph.D., August 7, 2025

Industry Reports

- “2024 Condition-Specific Readmission Measures Updates and Specifications Report,” Yale New Haven Health Services Corporation — Center for Outcomes Research and Evaluation, April 2024, available at https://qualitynet.cms.gov/files/663548ea2b87360fd3523eff?filename=2024_CSR_US_Report_v1.0.pdf
- Marcus Berzofsky et al., “Estimation Procedures for Crimes in the United States Based on NIBRS Data,” *Bureau of Justice Statistics*, August 2022, available at <https://bjs.ojp.gov/content/pub/pdf/epcusbnibrsd.pdf>
- Matt Austin and Jordan Derk, “Lives Lost, Lives Saved: An Updated Comparative Analysis of Avoidable Deaths at Hospitals Graded by The Leapfrog Group,” *Armstrong Institute for Patient Safety and Quality Johns Hopkins Medicine* (2019)

Legal Documents

- Complaint and Demand for Jury Trial, *Good Samaritan Medical Center, Inc., Delray Medical Center, Inc., Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center, St. Mary’s Medical Center, Inc., and West Boca Medical Center, Inc. v. The Leapfrog Group*, Case No. 9:25-cv-80526, April 30, 2025
- Defendant The Leapfrog Group’s Motion to Dismiss Pursuant to Federal Rule of Civil Procedure 12(b)(2) and 12(b)(6) and Incorporated Memorandum of Law in Support of the Same, *Good Samaritan Medical Center, et al. v. The Leapfrog Group*, Case No. 9:25-cv-80526-DMM, June 27, 2025
- Defendant The Leapfrog Group’s Responses to Plaintiffs’ Requests for Production, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, Case No. 9:25-CV-80526-DMM, July 1, 2025
- Plaintiff Delray Medical Center, Inc.’s Responses and Objections to Defendant The Leapfrog Group’s First Set of Interrogatories to Delray Medical Center, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, Case No. 9:25-CV-80526-DMM, July 25, 2025

- Plaintiff Good Samaritan Medical Center, Inc.’s Responses and Objections to Defendant The Leapfrog Group’s First Set of Interrogatories to Good Samaritan Medical Center, Inc., *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, Case No. 9:25-CV-80526-DMM, July 25, 2025
- Plaintiff Palm Beach Gardens Medical Center’s Responses and Objections to Defendant The Leapfrog Group’s First Set of Interrogatories to Palm Beach Gardens Medical Center, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, Case No. 9:25-CV-80526-DMM, July 25, 2025
- Plaintiff St. Mary’s Medical Center, Inc.’s Responses and Objections to Defendant The Leapfrog Group’s First Set of Interrogatories to St. Mary’s Medical Center, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, Case No. 9:25-CV-80526-DMM, July 25, 2025
- Plaintiff West Boca Medical Center, Inc.’s Responses and Objections to Defendant The Leapfrog Group’s First Set of Interrogatories to West Boca Medical Center, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, Case No. 9:25-CV-80526-DMM, July 25, 2025

Press Releases

- The Leapfrog Group, “Leapfrog’s Spring 2025 Safety Grades Are In — New Trend Data Shows One in Eight Hospitals Sustained an ‘A’ for More Than Two Years,” May 1, 2025, available at <https://www.leapfroggroup.org/news-events/leapfrog%E2%80%99s-spring-2025-safety-grades-are-%E2%80%94-new-trend-data-shows-one-eight-hospitals>

Transcripts

- Transcription of YouTube Video: The Leapfrog Hospital Safety Grade, *Good Samaritan Medical Center, Inc., et al v. The Leapfrog Group*, Case No. 9:25-cv-80526, May 15, 2025

Websites

- “About the Grade,” *The Leapfrog Group*, available at <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/about-the-grade>
- “About the Leapfrog Group,” *The Leapfrog Group*, November 15, 2024, available at <https://www.hospitalsafetygrade.org/about-the-score/about-the-leapfrog-group>
- “After Surgery: Discomforts and Complications,” Johns Hopkins Medicine, <https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/after-surgery-discomforts-and-complications>

- “Audits and Penalties,” *CMS.gov*, September 10, 2024, available at <https://www.cms.gov/OpenPayments/Program-Participants/Reporting-Entities/Audits-and-Penalties>
- “Choosing the Best Hospital,” *Leapfrog Hospital Safety Grade*, available at <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/choosing-the-best-hospital>
- “CMS Inpatient Value, Incentives, and Quality Reporting Programs Overview,” *Quality Reporting Center*, December 2020, available at https://www.qualityreportingcenter.com/globalassets/2021/06/cms-iviqr-programs-overview_fy-2023_vfinal508.pdf
- “CMS Quality Reporting Programs Frequently Asked Questions,” *CDC*, March 15, 2023, available at https://www.cdc.gov/nhsn/faqs/cms/faq_cms_hai.html
- “Data Editing and Imputation,” *U.S. Census Bureau*, available at <https://www.census.gov/programs-surveys/sipp/methodology/data-editing-and-imputation.html>
- “Data Quality Guidelines Overview,” *U.S. Bureau of Justice Statistics*, available at <https://bjs.ojp.gov/bjs-data-quality-guidelines/overview#22-0>
- “Delray Medical Center,” *The Leapfrog Group*, available at <https://www.hospitalsafetygrade.org/h/delray-medical-center>
- “Delray Medical Center,” *The Leapfrog Group*, available at <https://ratings.leapfroggroup.org/facility/details/10-0258/delray-medical-center-delray-beach-fl>
- “Explanation of Hospital Safety Grades,” *The Leapfrog Group*, April 2025, available at https://www.hospitalsafetygrade.org/media/file/ExplanationofSafetyGrades_Spring2025.pdf
- “Federal Deemed Status Fact Sheet,” *The Joint Commission*, available at <https://www.jointcommission.org/resources/news-and-multimedia/fact-sheets/facts-about-federal-deemed-status/>
- “Final Updates to the Leapfrog Hospital Safety Grade Methodology for Fall 2024,” *The Leapfrog Group*, available at https://www.hospitalsafetygrade.org/media/file/Fall2024HospitalSafetyGrade_FinalMethodologyChanges.pdf
- “Finding Medicare Fee-For-Service (FFS) Payment System Rules: Schedules and Resources,” *Congress.gov*, January 7, 2025, available at <https://www.congress.gov/crs-product/R46797>

- “Follow-Up Statement from Leapfrog President and CEO Leah Binder on Tenet Healthcare Hospitals’ Lawsuit to Suppress Poor Safety Grade Performance,” *The Leapfrog Group*, May 2, 2025, available at <https://www.leapfroggroup.org/news-events/follow-statement-leapfrog-president-and-ceo-leah-binder-tenet-healthcare-hospitals%E2%80%99>
- “Frequently Asked Questions About the Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, May 1, 2025, available at <https://www.hospitalsafetygrade.org/frequently-asked-questions>
- “Good Samaritan Medical Center,” *The Leapfrog Group*, available at <https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center>
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- “HCAHPS: Patients’ Perspectives of Care Survey,” *CMS.gov*, September 10, 2024, available at <https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hcahps-patients-perspectives-care-survey>
- “Health Care Ratings and Reports,” *The Leapfrog Group*, available at <https://www.leapfroggroup.org/ratings-reports>
- “History of the Joint Commission,” *The Joint Commission*, available at <https://www.jointcommission.org/who-we-are/facts-about-the-joint-commission/history-of-the-joint-commission/>
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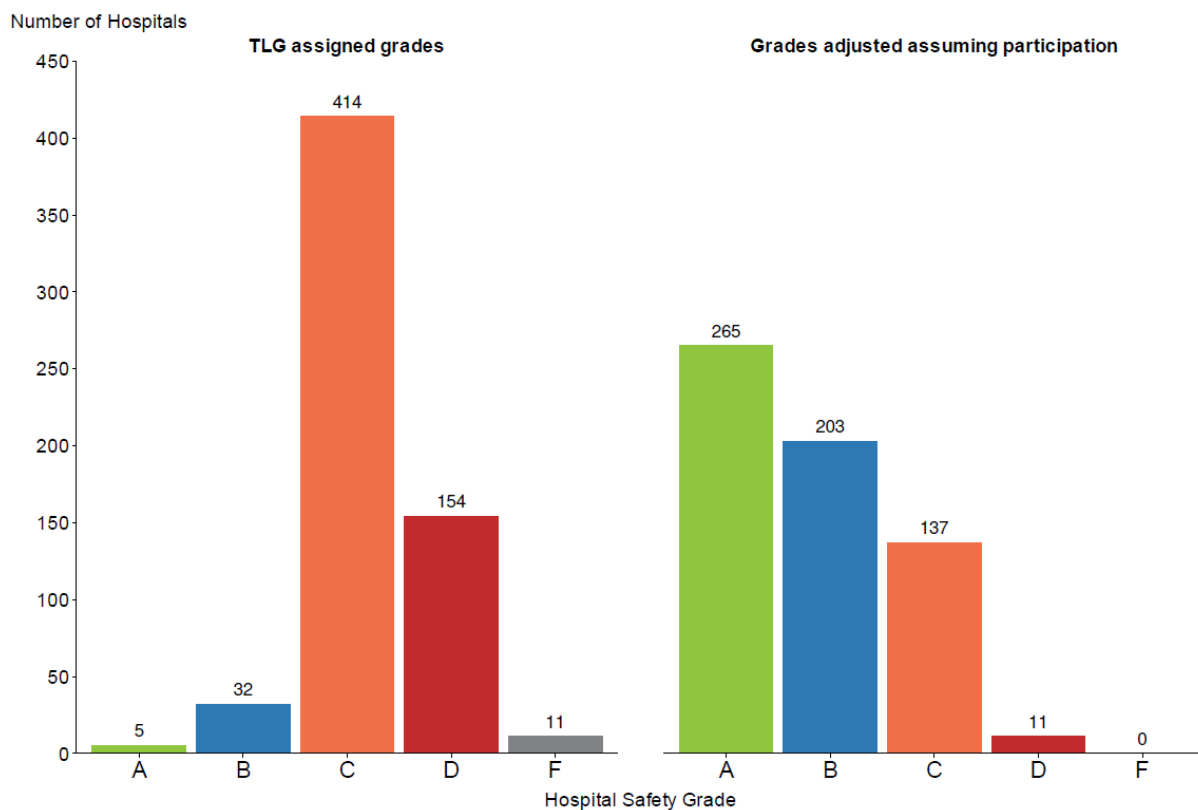
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Note: In addition to the documents on this list, I relied on all documents cited in my report to form my opinions.

Appendix D
TLG's Methodology Penalizes Non-Participating Hospitals (Fall 2024)



Source: TLG Hospital Safety Grade data

Note: This figure demonstrates the impact of rescoring seven of the total 12 measures that hospitals participating in TLG's survey self-report. These seven measures are the ones that for non-participating hospitals, TLG either imputes the lowest possible value (Computerized Physician Order Entry (CPOE), Bar Code Medication Administration (BCMA), ICU Physician Staffing (IPS), Hand Hygiene) or omits in the calculation of the final grade (Safe Practice 1: Culture of Safety Leadership Structures and Systems, Safe Practice 2: Culture Measurement, Feedback, and Intervention, and Total Nursing Care Hours per Patient Day). By contrast, as shown in Exhibit 2, on each of these measures, 50% or more of participating hospitals self-report the maximum possible score. As a result, to construct the counterfactual grades that TLG would have assigned Plaintiffs had they participated in the survey, I conservatively rescore each of the seven measures to be the average score reported by participating hospitals. This rescoring does not affect TLG's "Step 1" imputation. If TLG uses historical data to calculate a previously participating hospital's score on a given measure, this analysis does so too. TLG's "Step 1" imputation affects 48 out of 616 non-participating hospitals.

Workpaper 1

	Overall Score	Letter Grade
Mean Values	3.00	B
TLG Imputed Values	2.59	C

Source: "Explanation of Hospital Safety Grades," The Leapfrog Group, April 2025, available at https://www.hospitalsafetygrade.org/media/file/ExplanationofSafetyGrades_Spring2025.pdf, p. 2; "Leapfrog Hospital Safety Grade Scoring Methodology," *The Leapfrog Group*, April 21, 2025, available at <https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025.pdf>, pp. 4–7, 15–17, 20, 22.

weights	Standard Measure Weight	Standard Measure Weight	
scores	Mean Score	Imputed Score	Standard Deviation
Measure	Mean Score Weighted	Imputed Score Weighted	Imputed Score Z-Score
CPOE	4.97426	0.93	-0.118461043
BCMA	4.9122	1.5	-0.112059113
IPS	4.49535	0.345	-0.09490853
SP 1	3.64219	NA	NA
SP 2	3.7392	NA	NA
Total Nursing Care Hours per Patient Day	3.62229	NA	NA
HHS	3.6456	0.735	-0.080536801
H-COMP-1	2.7057	NA	NA
H-COMP-2	2.6973	NA	NA
H-COMP-3	2.4489	NA	NA
H-COMP-5	2.30702	NA	NA
H-COMP-6	2.5575	NA	NA
Foreign Object Retained	0.000588	NA	NA
Air Embolism	0.000048	NA	NA
Falls and Trauma	0.018816	NA	NA
CLABSI	0.029295	NA	NA
CAUTI	0.02538	NA	NA
SSI Colon	0.028254	NA	NA
MRSA	0.032355	NA	NA
C. Diff.	0.018045	NA	NA
PSI 4	3.54904	NA	NA
PSI 90	0.1503	NA	NA

Appendix E

Measure	Evidence Score	Opportunity Score	Impact Score	Number of Component Measures	Standard Measure Weight
Process/Structural Measure Domain (50%)					
CPOE	2	1.43	3	1	6.2%
BCMA	2	1.37	3	1	6.0%
IPS	2	1.67	3	1	6.9%
SP 1	1	1.06	2	1	3.1%
SP 2	1	1.12	2	1	3.2%
Total Nursing Care Hours per Patient Day	2	1.41	2	1	4.7%
HHS	2	1.49	2	1	4.9%
H-COMP-1	1	1.03	2	1	3.0%
H-COMP-2	1	1.03	2	1	3.0%
H-COMP-3	1	1.05	2	1	3.0%
H-COMP-5	1	1.06	2	1	3.1%
H-COMP-6	1	1.04	2	1	3.0%
Outcome Measure Domain (50%)					
Foreign Object Retained	1	3.00	2	1	4.2%
Air Embolism	1	3.00	1	1	2.4%
Falls and Trauma	2	2.05	3	1	4.9%
CLABSI	2	1.85	3	1	4.5%
CAUTI	2	1.91	3	1	4.7%
SSI Colon	2	1.83	2	1	3.4%
MRSA	2	1.82	3	1	4.5%
C. Diff.	2	1.81	3	1	4.5%
PSI 4	1	1.14	2	1	2.0%
PSI 90	1	1.20	2	10	15.0%

Appendix E

Measure	Mean Score	Standard Deviation	Imputed Score
CPOE	80.23	34.14	15
BCMA	81.87	30.45	25
IPS	65.15	43.73	5
SP 1	117.49	6.79	NA
SP 2	116.85	13.98	NA
Total Nursing Care Hours per Patient Day	77.07	31.61	NA
HHS	74.4	36.14	15
H-COMP-1	90.19	2.51	NA
H-COMP-2	89.91	2.48	NA
H-COMP-3	81.63	4.36	NA
H-COMP-5	74.42	4.13	NA
H-COMP-6	85.25	3.7	NA
Foreign Object Retained	0.014	0.05	NA
Air Embolism	0.002	0.055	NA
Falls and Trauma	0.384	0.402	NA
CLABSI	0.651	0.552	NA
CAUTI	0.54	0.494	NA
SSI Colon	0.831	0.689	NA
MRSA	0.719	0.591	NA
C. Diff.	0.401	0.326	NA
PSI 4	177.452	24.02	NA
PSI 90	1.002	0.196	NA

Workpaper 2

Measure	Primary Data Source	Secondary Data Source	Standard Measure Weight
<i>Process Structural</i>			
CPOE	Survey	Imputation	6.2%
BCMA	Survey	Imputation	6.0%
IPS	Survey	Imputation	6.9%
SP 1	Survey	-	3.1%
SP 2	Survey	-	3.2%
Total Nursing Care Hours per Patient Day	Survey	-	4.7%
HHS	Survey	Imputation	4.9%
H-COMP-1	CMS	-	3.0%
H-COMP-2	CMS	-	3.0%
H-COMP-3	CMS	-	3.0%
H-COMP-5	CMS	-	3.1%
H-COMP-6	CMS	-	3.0%
<i>Outcome</i>			
Foreign Object Retained	CMS	-	4.2%
Air Embolism	CMS	-	2.4%
Falls and Trauma	CMS	-	4.9%
CLABSI	Survey	CMS	4.5%
CAUTI	Survey	CMS	4.7%
SSI Colon	Survey	CMS	3.4%
MRSA	Survey	CMS	4.5%
C. Diff.	Survey	CMS	4.5%
PSI 4	CMS	-	2.0%
PSI 90	CMS	-	15.0%
<i>Total Weight by Data Source</i>			
CMS			43.6%
Survey			56.6%
Imputation			24.0%

Source: "Leapfrog Hospital Safety Grade Scoring Methodology," *The Leapfrog Group*, April 21, 2025, available at <https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025.pdf>, pp. 4–7, 20.

Note: The total weights reported in TLG's scoring methodology do not add up to 100%. Adjusting the weights to add up to 100% do not meaningfully change the weights.

Workpaper 3

Appendix E

Hospital name	Spring 2025 TLG grade	Participated in TLG survey?	TLG grade source	Survey participation source
AdventHealth Altamonte Springs	A	Y	Link	Link
AdventHealth Carrollwood	A	Y	Link	Link
AdventHealth Celebration	A	Y	Link	Link
AdventHealth DeLand	A	Y	Link	Link
AdventHealth East Orlando	A	Y	Link	Link
AdventHealth Fish Memorial	A	Y	Link	Link
AdventHealth Ocala	A	Y	Link	Link
AdventHealth Orlando	A	Y	Link	Link
AdventHealth Wesley Chapel	A	Y	Link	Link
AdventHealth Winter Park	A	Y	Link	Link
Ascension Sacred Heart Pensacola	A	Y	Link	Link
Baptist Health Homestead Hospital	A	Y	Link	Link
Baptist Medical Center Beaches	A	Y	Link	Link
Baptist Medical Center Nassau	A	Y	Link	Link
Cape Coral Hospital	A	Y	Link	Link
HCA Florida North Florida Hospital	A	Y	Link	Link
HCA Florida Sarasota Doctors Hospital	A	Y	Link	Link
HCA Florida St. Lucie Hospital	A	Y	Link	Link
HCA Florida Westside Hospital	A	Y	Link	Link
Healthpark Medical Center	A	Y	Link	Link
Jupiter Medical Center	A	Y	Link	Link
Larkin Community Hospital	A	Y	Link	Link
Lee Memorial Hospital	A	Y	Link	Link
Mayo Clinic-Jacksonville	A	Y	Link	Link
Mease Countryside Hospital	A	Y	Link	Link
Mease Dunedin Hospital	A	Y	Link	Link
Morton Plant Hospital	A	Y	Link	Link
Morton Plant North Bay Hospital	A	Y	Link	Link
Orlando Health South Lake Hospital	A	Y	Link	Link
Oviedo Medical Center	A	Y	Link	Link
Sarasota Memorial Hospital	A	Y	Link	Link
St. Anthony's Hospital	A	Y	Link	Link
St. Joseph's Hospital	A	Y	Link	Link
St. Joseph's Hospital - North	A	Y	Link	Link
St. Joseph's Hospital - South	A	Y	Link	Link
UF Health Shands Hospital	A	Y	Link	Link
AdventHealth Apopka	A	Y	Link	Link
AdventHealth Dade City	A	Y	Link	Link
AdventHealth Kissimmee	A	Y	Link	Link
AdventHealth Lake Wales	A	Y	Link	Link
AdventHealth New Smyrna Beach	A	Y	Link	Link
AdventHealth North Pinellas	A	Y	Link	Link
AdventHealth Winter Garden	A	Y	Link	Link
AdventHealth Zephyrhills	A	Y	Link	Link
Baptist Health Hospital Doral	A	Y	Link	Link
Baptist Health South Miami Hospital	A	Y	Link	Link
Baptist Health West Kendall Baptist Hospital	A	Y	Link	Link
Baptist Medical Center Clay	A	Y	Link	Link
Bartow Regional Medical Center	A	Y	Link	Link
Broward Health Coral Springs	A	Y	Link	Link
Broward Health North	A	Y	Link	Link
Coral Gables Hospital	A	Y	Link	Link
HCA Florida Highlands Hospital	A	Y	Link	Link
HCA Florida Kendall Hospital	A	Y	Link	Link
HCA Florida Raulerson Hospital	A	Y	Link	Link
HCA Florida South Tampa Hospital	A	Y	Link	Link
HCA Florida Trinity Hospital	A	Y	Link	Link
Hialeah Hospital	A	Y	Link	Link
Holmes Regional Medical Center	A	Y	Link	Link
Lakewood Ranch Medical Center	A	Y	Link	Link
Larkin Community Hospital - Palm Springs Campus	A	Y	Link	Link
Memorial Hospital Miramar	A	Y	Link	Link
Memorial Hospital Pembroke	A	Y	Link	Link
Orlando Health Bayfront Hospital	A	Y	Link	Link
Orlando Health Horizon West Hospital	A	Y	Link	Link
Orlando Health Melbourne Hospital	A	Y	Link	Link
Sarasota Memorial Hospital - Venice	A	Y	Link	Link
St. Vincent's Medical Center Clay County	A	Y	Link	Link

Appendix E

Hospital name	Spring 2025 TLG grade	Participated in TLG survey?	TLG grade source	Survey participation source
St. Vincent's Medical Center Southside	A	Y	Link	Link
Winter Haven Hospital	A	Y	Link	Link
AdventHealth Daytona Beach	B	Y	Link	Link
AdventHealth Heart of Florida	B	Y	Link	Link
AdventHealth Palm Coast	B	Y	Link	Link
AdventHealth Sebring	B	Y	Link	Link
AdventHealth Waterman	B	Y	Link	Link
Ascension St. Vincent's Riverside	B	Y	Link	Link
Baptist Health Baptist Hospital of Miami	B	Y	Link	Link
Baptist Health Boca Raton Regional Hospital	B	Y	Link	Link
Baptist Health Doctors Hospital	B	Y	Link	Link
Baptist Medical Center Jacksonville	B	Y	Link	Link
Baptist Medical Center South	B	Y	Link	Link
Cape Canaveral Hospital	B	Y	Link	Link
Cleveland Clinic Hospital Weston	B	Y	Link	Link
Cleveland Clinic Indian River Hospital	B	Y	Link	Link
Gulf Coast Medical Center	B	Y	Link	Link
HCA Florida Aventura Hospital	B	Y	Link	Link
HCA Florida Blake Hospital	B	Y	Link	Link
HCA Florida Brandon Hospital	B	Y	Link	Link
HCA Florida Capital Hospital	B	Y	Link	Link
HCA Florida Englewood Hospital	B	Y	Link	Link
HCA Florida Fort Walton-Destin Hospital	B	Y	Link	Link
HCA Florida Gulf Coast Hospital	B	Y	Link	Link
HCA Florida Lake City Hospital	B	Y	Link	Link
HCA Florida Lawnwood Hospital	B	Y	Link	Link
HCA Florida Oak Hill Hospital	B	Y	Link	Link
HCA Florida Orange Park Hospital	B	Y	Link	Link
HCA Florida Osceola Hospital	B	Y	Link	Link
HCA Florida Pasadena Hospital	B	Y	Link	Link
HCA Florida South Shore Hospital	B	Y	Link	Link
HCA Florida St. Petersburg Hospital	B	Y	Link	Link
HCA Florida Twin Cities Hospital	B	Y	Link	Link
HCA Florida University Hospital	B	Y	Link	Link
HCA Florida West Hospital	B	Y	Link	Link
HCA Florida Woodmont Hospital	B	Y	Link	Link
Holy Cross Hospital	B	Y	Link	Link
Jackson West Medical Center	B	Y	Link	Link
Lehigh Regional Medical Center	B	Y	Link	Link
Lower Keys Medical Center	B	Y	Link	Link
Memorial Regional Hospital	B	Y	Link	Link
Naval Hospital Jacksonville	B	Y	Link	Link
NCH North Naples Hospital	B	Y	Link	Link
Orlando Health Dr. P. Phillips Hospital	B	Y	Link	Link
Orlando Health Lake Mary Hospital	B	Y	Link	Link
Orlando Health Sebastian River Hospital	B	Y	Link	Link
Orlando Health St. Cloud Hospital	B	Y	Link	Link
Orlando Health - Health Central Hospital	B	Y	Link	Link
Orlando Health - Orlando Regional Medical Center	B	Y	Link	Link
Palm Bay Hospital	B	Y	Link	Link
Sacred Heart Hospital On The Emerald Coast	B	Y	Link	Link
South Florida Baptist Hospital	B	Y	Link	Link
Tallahassee Memorial Healthcare	B	Y	Link	Link
UCF Lake Nona Medical Center	B	Y	Link	Link
UF Health Jacksonville	B	Y	Link	Link
UF Health Leesburg Hospital	B	Y	Link	Link
UF Health North	B	Y	Link	Link
UF Health-Spanish Plaines	B	Y	Link	Link
Viera Hospital	B	Y	Link	Link
AdventHealth Lake Placid	C	Y	Link	Link
AdventHealth Port Charlotte	C	Y	Link	Link
AdventHealth Tampa	C	Y	Link	Link
Ascension Sacred Heart Hospital Bay	C	Y	Link	Link
Ascension St. Vincent's St. Johns County	C	N	Link	Link
Baptist Health Bethesda Hospital East	C	Y	Link	Link
Baptist Health Bethesda Hospital West	C	Y	Link	Link
Baptist Hospital	C	N	Link	Link
Broward Health Imperial Point	C	Y	Link	Link

Hospital name	Spring 2025 TLG grade	Participated in TLG survey?	TLG grade source	Survey participation source
Broward Health Medical Center	C	Y	Link	Link
Cleveland Clinic Martin North Hospital	C	Y	Link	Link
Cleveland Clinic Martin South Hospital	C	Y	Link	Link
Cleveland Clinic Tradition Hospital	C	Y	Link	Link
Desoto Memorial Hospital	C	N	Link	Link
Flagler Hospital	C	Y	Link	Link
Florida Medical Center	C	Y	Link	Link
Gulf Breeze Hospital	C	N	Link	Link
Halifax Health Medical Center	C	Y	Link	Link
Halifax Health UF Medical Center of Deltona Hospital	C	Y	Link	Link
HCA Florida Bayonet Point Hospital	C	Y	Link	Link
HCA Florida Citrus Hospital	C	Y	Link	Link
HCA Florida Fawcett Hospital	C	Y	Link	Link
HCA Florida JFK Hospital	C	Y	Link	Link
HCA Florida JFK North Hospital, A part of HCA Florida JFK Hospital	C	Y	Link	Link
HCA Florida Lake Monroe Hospital	C	Y	Link	Link
HCA Florida Largo Hospital	C	Y	Link	Link
HCA Florida Memorial Hospital	C	Y	Link	Link
HCA Florida Mercy Hospital	C	Y	Link	Link
HCA Florida Northside Hospital	C	Y	Link	Link
HCA Florida Northwest Hospital	C	Y	Link	Link
HCA Florida Palms West Hospital	C	Y	Link	Link
HCA Florida Poinciana Hospital	C	Y	Link	Link
HCA Florida Putnam Hospital	C	Y	Link	Link
HCA Florida West Marion Hospital	C	Y	Link	Link
Jackson Hospital	C	Y	Link	Link
Jackson Memorial Hospital	C	Y	Link	Link
Jackson North Medical Center	C	Y	Link	Link
Jackson South Medical Center	C	Y	Link	Link
Keralty Hospital Miami	C	N	Link	Link
Lakeland Regional Medical Center	C	Y	Link	Link
Manatee Memorial Hospital	C	Y	Link	Link
Memorial Hospital West	C	Y	Link	Link
Memorial Regional Hospital South	C	Y	Link	Link
Mount Sinai Medical Center	C	Y	Link	Link
NCH Baker Hospital	C	Y	Link	Link
North Okaloosa Medical Center	C	Y	Link	Link
North Shore Medical Center	C	Y	Link	Link
Palmetto General Hospital	C	Y	Link	Link
Parrish Medical Center	C	Y	Link	Link
Physicians Regional Healthcare System - Collier Boulevard	C	Y	Link	Link
Physicians Regional Healthcare System - Pine Ridge	C	Y	Link	Link
Santa Rosa Medical Center	C	Y	Link	Link
Tampa General Hospital	C	Y	Link	Link
Tampa General Hospital Brooksville	C	Y	Link	Link
Tampa General Hospital Crystal River	C	Y	Link	Link
Tampa General Hospital Spring Hill	C	Y	Link	Link
Wellington Regional Medical Center	C	Y	Link	Link
Good Samaritan Medical Center	D	N	Link	Link
Halifax Health Medical Center - Port Orange	D	Y	Link	Link
HCA Florida Ocala Hospital	D	Y	Link	Link
St. Mary's Medical Center	D	N	Link	Link
Delray Medical Center	F	N	Link	Link
Palm Beach Gardens Medical Center	F	N	Link	Link
West Boca Medical Center	F	N	Link	Link

Workpaper 4

Appendix E

Share of A- and B-graded TLG hospitals in
Florida known to have CMS rating of 3 or
lower: 50.39%

National average CMS star rating among
hospitals that receive a rating: 3.14

Hospital name	Spring 2025 TLG grade	CMS Star Rating	TLG grade source	CMS Star Rating source
AdventHealth Altamonte Springs	A	Hospital not identified in CMS	Link	
AdventHealth Carrollwood	A	4	Link	Link
AdventHealth Celebration	A	Hospital not identified in CMS	Link	
AdventHealth DeLand	A	4	Link	CMS National Hospital Data
AdventHealth East Orlando	A	Hospital not identified in CMS	Link	
AdventHealth Fish Memorial	A	4	Link	CMS National Hospital Data
AdventHealth Ocala	A	3	Link	CMS National Hospital Data
AdventHealth Orlando	A	3	Link	CMS National Hospital Data
AdventHealth Wesley Chapel	A	4	Link	CMS National Hospital Data
AdventHealth Winter Park	A	Hospital not identified in CMS	Link	
Ascension Sacred Heart Pensacola	A	4	Link	Link
Baptist Health Homestead Hospital	A	4	Link	Link
Baptist Medical Center Beaches	A	4	Link	Link
Baptist Medical Center Nassau	A	4	Link	Link
Cape Coral Hospital	A	4	Link	CMS National Hospital Data
HCA Florida North Florida Hospital	A	2	Link	CMS National Hospital Data
HCA Florida Sarasota Doctors Hospital	A	4	Link	CMS National Hospital Data
HCA Florida St. Lucie Hospital	A	1	Link	Link
HCA Florida Westside Hospital	A	3	Link	Link
Healthpark Medical Center	A	Hospital not identified in CMS	Link	
Jupiter Medical Center	A	4	Link	CMS National Hospital Data
Larkin Community Hospital	A	Not available	Link	CMS National Hospital Data
Lee Memorial Hospital	A	5	Link	CMS National Hospital Data
Mayo Clinic-Jacksonville	A	5	Link	Link
Mease Countryside Hospital	A	5	Link	CMS National Hospital Data
Mease Dunedin Hospital	A	5	Link	CMS National Hospital Data
Morton Plant Hospital	A	4	Link	CMS National Hospital Data
Morton Plant North Bay Hospital	A	3	Link	CMS National Hospital Data
Orlando Health South Lake Hospital	A	3	Link	CMS National Hospital Data
Oviedo Medical Center	A	4	Link	CMS National Hospital Data
Sarasota Memorial Hospital	A	5	Link	CMS National Hospital Data
St. Anthony's Hospital	A	4	Link	Link
St. Joseph's Hospital	A	4	Link	Link
St. Joseph's Hospital - North	A	Hospital not identified in CMS	Link	
St. Joseph's Hospital - South	A	Hospital not identified in CMS	Link	
UF Health Shands Hospital	A	4	Link	CMS National Hospital Data
AdventHealth Apopka	A	Hospital not identified in CMS	Link	
AdventHealth Dade City	A	4	Link	CMS National Hospital Data
AdventHealth Kissimmee	A	Hospital not identified in CMS	Link	
AdventHealth Lake Wales	A	1	Link	CMS National Hospital Data
AdventHealth New Smyrna Beach	A	3	Link	CMS National Hospital Data
AdventHealth North Pinellas	A	3	Link	CMS National Hospital Data
AdventHealth Winter Garden	A	Hospital not identified in CMS	Link	
AdventHealth Zephyrhills	A	Hospital not identified in CMS	Link	
Baptist Health Hospital Doral	A	Hospital not identified in CMS	Link	
Baptist Health South Miami Hospital	A	5	Link	Link
Baptist Health West Kendall Baptist Hospital	A	5	Link	Link
Baptist Medical Center Clay	A	Hospital not identified in CMS	Link	
Bartow Regional Medical Center	A	3	Link	CMS National Hospital Data
Broward Health Coral Springs	A	2	Link	CMS National Hospital Data
Broward Health North	A	2	Link	CMS National Hospital Data
Coral Gables Hospital	A	3	Link	Link
HCA Florida Highlands Hospital	A	1	Link	CMS National Hospital Data
HCA Florida Kendall Hospital	A	2	Link	CMS National Hospital Data
HCA Florida Raulerson Hospital	A	3	Link	Link
HCA Florida South Tampa Hospital	A	3	Link	CMS National Hospital Data
HCA Florida Trinity Hospital	A	3	Link	CMS National Hospital Data
Hialeah Hospital	A	1	Link	Link
Holmes Regional Medical Center	A	3	Link	CMS National Hospital Data
Lakewood Ranch Medical Center	A	3	Link	CMS National Hospital Data
Larkin Community Hospital - Palm Springs Campus	A	3	Link	Link
Memorial Hospital Miramar	A	4	Link	CMS National Hospital Data
Memorial Hospital Pembroke	A	2	Link	CMS National Hospital Data
Orlando Health Bayfront Hospital	A	1	Link	CMS National Hospital Data
Orlando Health Horizon West Hospital	A	Hospital not identified in CMS	Link	
Orlando Health Melbourne Hospital	A	2	Link	Link
Sarasota Memorial Hospital - Venice	A	4	Link	CMS National Hospital Data

Appendix E

Hospital name	Spring 2025 TLG grade	CMS Star Rating	TLG grade source	CMS Star Rating source
St. Vincent's Medical Center Clay County	A	3	Link	Link
St. Vincent's Medical Center Southside	A	4	Link	Link
Winter Haven Hospital	A	2	Link	CMS National Hospital Data
AdventHealth Daytona Beach	B	5	Link	CMS National Hospital Data
AdventHealth Heart of Florida	B	1	Link	CMS National Hospital Data
AdventHealth Palm Coast	B	3	Link	Link
AdventHealth Sebring	B	3	Link	CMS National Hospital Data
AdventHealth Waterman	B	4	Link	CMS National Hospital Data
Ascension St. Vincent's Riverside	B	2	Link	Link
Baptist Health Baptist Hospital of Miami	B	4	Link	Link
Baptist Health Boca Raton Regional Hospital	B	2	Link	Link
Baptist Health Doctors Hospital	B	5	Link	Link
Baptist Medical Center Jacksonville	B	4	Link	Link
Baptist Medical Center South	B	Hospital not identified in CMS	Link	
Cape Canaveral Hospital	B	4	Link	CMS National Hospital Data
Cleveland Clinic Hospital Weston	B	3	Link	Link
Cleveland Clinic Indian River Hospital	B	4	Link	CMS National Hospital Data
Gulf Coast Medical Center	B	4	Link	Link
HCA Florida Aventura Hospital	B	2	Link	CMS National Hospital Data
HCA Florida Blake Hospital	B	1	Link	CMS National Hospital Data
HCA Florida Brandon Hospital	B	3	Link	CMS National Hospital Data
HCA Florida Capital Hospital	B	1	Link	CMS National Hospital Data
HCA Florida Englewood Hospital	B	3	Link	CMS National Hospital Data
HCA Florida Fort Walton-Destin Hospital	B	3	Link	CMS National Hospital Data
HCA Florida Gulf Coast Hospital	B	3	Link	CMS National Hospital Data
HCA Florida Lake City Hospital	B	3	Link	CMS National Hospital Data
HCA Florida Lawnwood Hospital	B	1	Link	CMS National Hospital Data
HCA Florida Oak Hill Hospital	B	3	Link	CMS National Hospital Data
HCA Florida Orange Park Hospital	B	2	Link	CMS National Hospital Data
HCA Florida Osceola Hospital	B	2	Link	CMS National Hospital Data
HCA Florida Pasadena Hospital	B	3	Link	CMS National Hospital Data
HCA Florida South Shore Hospital	B	2	Link	CMS National Hospital Data
HCA Florida St. Petersburg Hospital	B	2	Link	Link
HCA Florida Twin Cities Hospital	B	4	Link	CMS National Hospital Data
HCA Florida University Hospital	B	3	Link	CMS National Hospital Data
HCA Florida West Hospital	B	2	Link	CMS National Hospital Data
HCA Florida Woodmont Hospital	B	1	Link	Link
Holy Cross Hospital	B	3	Link	CMS National Hospital Data
Jackson West Medical Center	B	Hospital not identified in CMS	Link	
Lehigh Regional Medical Center	B	3	Link	CMS National Hospital Data
Lower Keys Medical Center	B	3	Link	CMS National Hospital Data
Memorial Regional Hospital	B	3	Link	CMS National Hospital Data
Naval Hospital Jacksonville	B	Not available	Link	Link
NCH North Naples Hospital	B	Hospital not identified in CMS	Link	
Orlando Health Dr. P. Phillips Hospital	B	Hospital not identified in CMS	Link	
Orlando Health Lake Mary Hospital	B	Hospital not identified in CMS	Link	
Orlando Health Sebastian River Hospital	B	3	Link	Link
Orlando Health St. Cloud Hospital	B	2	Link	Link
Orlando Health - Health Central Hospital	B	2	Link	Link
Orlando Health - Orlando Regional Medical Center	B	2	Link	Link
Palm Bay Hospital	B	4	Link	CMS National Hospital Data
Sacred Heart Hospital On The Emerald Coast	B	5	Link	CMS National Hospital Data
South Florida Baptist Hospital	B	4	Link	CMS National Hospital Data
Tallahassee Memorial Healthcare	B	2	Link	CMS National Hospital Data
UCF Lake Nona Medical Center	B	Not available	Link	Link
UF Health Jacksonville	B	3	Link	Link
UF Health Leesburg Hospital	B	2	Link	CMS National Hospital Data
UF Health North	B	Hospital not identified in CMS	Link	
UF Health-Spanish Plains	B	1	Link	Link
Viera Hospital	B	5	Link	CMS National Hospital Data

Workpaper 5

Appendix E

Hospital	TLG Spring 2025		Mean Value for Process/Structural Measures	
	Score	Grade	Score	Grade
Delray	1.6430	F	2.4315	C
Good Samaritan	1.9638	D	2.6810	C
PB Gardens	1.7777	F	2.5057	C
St. Mary's	2.2512	D	2.9341	C
West Boca	1.8346	F	2.5670	C

Appendix E

shorthand	hospital_name	tlg_normalized_score	tlg_grade	rescore_normalized_score	rescore_grade
PB Gardens	Palm Beach Gardens Medical Center	1.777689803	F	2.505705798	C
Delray	Delray Medical Center	1.642991426	F	2.431467843	C
West Boca	West Boca Medical Center	1.834637393	F	2.567038646	C
Good Samaritan	Good Samaritan Medical Center	1.963833267	D	2.681023703	C
St. Mary's	St. Mary's Medical Center	2.251168586	D	2.934125334	C

Workpaper 6

Appendix E

TLG Results	P Value	Test Statistic	Share Participating A or B	Share Participating C or Lower	Difference	Conf Int Lower	Conf Int Upper	Method	Significant
Fall 2024	3.73E-180	817.7523	0.9767	0.5250	0.4517	0.4266	1	2-sample test for equality of proportions with continuity correction	Yes
Spring 2025	1.69E-181	823.9372	0.9837	0.5402	0.4435	0.4189	1	2-sample test for equality of proportions with continuity correction	Yes

Workpaper 7

Appendix E

Period	TLG Share C or Below	Rescore Share A or B
Spring 2025	0.95608	0.71115
Fall 2024	0.93994	0.75974

Workpaper 8

Appendix E

Measure	B - C: difference				C - D/F: difference				Measure Name
	of means	B - C: t statistic	B - C: p value	B - C: reject hypothesis	of means	C - D/F: t statistic	C - D/F: p value	C - D/F: reject hypothesis	
PSI_04_score	-6.3215	-4.3830	0.0000	Y	-4.2111	-1.9146	0.0567	N	Death among patients with serious treatable complications after surgery
PSI_90_score	-0.0647	-8.3912	0.0000	Y	-0.1564	-6.9438	0.0000	Y	Serious complications (this is a composite or summary measure)
HAI_1_SIR	-0.0980	-3.1145	0.0019	Y	-0.1304	-2.2863	0.0230	Y	Central line-associated bloodstream infections (CLABSI) in ICUs and select wards
HAI_2_SIR	-0.0475	-1.7252	0.0847	N	-0.1397	-2.7245	0.0068	Y	Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards
HAI_3_SIR	-0.0500	-1.1892	0.2346	N	-0.1228	-1.7033	0.0899	N	Surgical Site Infection from colon surgery (SSI: Colon)
HAI_5_SIR	-0.0312	-0.9020	0.3672	N	-0.1542	-2.2715	0.0241	Y	blood laboratory-identified events (bloodstream infections)
HAI_6_SIR	-0.0785	-4.7539	0.0000	Y	-0.1524	-4.5552	0.0000	Y	Clostridium difficile (C.diff) laboratory identified events (intestinal infections)
foreign_object	-0.0022	-0.3535	0.7238	N	-0.0031	-0.5198	0.6036	N	Foreign Object Retained
air_embolism	-0.0008	-1.4082	0.1593	N	0.0006	0.7948	0.4271	N	Air Embolism
falls_and_trauma	-0.0746	-3.2612	0.0011	Y	-0.1015	-2.6609	0.0081	Y	Falls and Trauma

EXHIBIT D

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

-----X

GOOD SAMARITAN MEDICAL CENTER, INC., et al,
PLAINTIFF,

-against-

Case No.:

9:25-cv-80526-DMM

THE LEAPFROG GROUP,

DEFENDANT.

-----X

DATE: September 2, 2025

TIME: 9:45 A.M.

VIDEOTAPED EXPERT DEPOSITION of THOMAS
CHAKURDA, held at Wilson, Elser, Moskowitz,
Edelman & Dicker, 150 East 42nd Street, New
York, New York, before Rivka Trop, a Notary
Public of the State of New York.

1 T. CHAKURDA

2 Q. You work with the Cornerstone
3 Group in putting these opinions together?

4 A. I had concert -- I had worked in
5 concert with them, I collaborated with them.

6 Q. And what services does the
7 Cornerstone Group provide to you to help you
8 produce your opinions in this matter?

9 A. I believe they assess my opinions
10 and my observations and synthesize that into
11 a document.

12 Q. So you have calls with the
13 Cornerstone Group to talk about your
14 opinions and then they put it into a
15 document, is that how that works?

16 A. These were done electronically.

17 Q. Were there any opinions that you
18 were asked to give in this matter that you
19 felt that you could not give?

20 A. No.

21 Q. In coming to your opinions in this
22 matter, did you speak with anyone at the
23 five hospitals?

24 A. No.

25 Q. In coming to your conclusions and

1 T. CHAKURDA

2 opinions in this matter, did you review any
3 of the marketing plans for any of the five
4 hospitals?

5 A. No.

6 Q. In coming to your conclusions and
7 opinions in this matter, did you assess the
8 brand of these five hospitals?

9 MS. PARKS: Objection, vague.

10 Q. You still have to answer that, if
11 you can?

12 A. Could you restate the question,
13 please.

14 Q. Yeah, that's another rule I should
15 tell you, if at any time you do not
16 understand one of my questions, it is a good
17 objection, I am happy to rephrase it?

18 A. Thank you.

19 Q. Let me just lay some foundation
20 for that then.

21 Are you aware of whether or not
22 there are any scientific methods that are
23 employed in order to make a determination
24 about a hospital's brand?

25 A. There are surveys, there are

1 T. CHAKURDA

2 ratings that have an impact in my view and
3 my opinion on the brand and the cache of the
4 brand.

5 Q. And I understand those things can
6 have impact on the brand. But I guess my
7 question is a little more general.

8 You understand that these five
9 hospitals complain that due to a change in
10 the Leapfrog grading methodology in November
11 of 2024, they are now being unfairly graded
12 in this, in the Leapfrog hospital safety
13 grades?

14 MS. PARKS: Objection to the
15 extent that misstates the record.

16 A. What I am opining on is the
17 impact, my opinions and my observations are
18 related to the impact of an F or a D grade
19 assigned to a hospital versus an A.

20 Q. Right, but wouldn't you have to
21 know what the brand was before they got the
22 F to determine what the impact was on the
23 brand?

24 A. I was aware of their previous
25 grades.

1 T. CHAKURDA

2 Q. So you are aware that some of
3 these hospitals had D grades previously?

4 A. Yes.

5 Q. Did you do any surveys in
6 connection with coming to your opinions to
7 determine whether or not any of these five
8 hospitals had a good brand or a bad brand
9 prior to November of 2024?

10 A. You have to understand, I spent
11 ten years in that market.

12 Q. Right?

13 A. So I was very aware of their
14 brands and of their presence.

15 Q. And the ten years you spent in
16 that market, I thought you told me you left
17 around 2019; correct?

18 A. Yes.

19 Q. And do you understand that these
20 five hospitals were purchased by Tenet
21 Hospital some time in or around 2019; is
22 that correct?

23 A. I am not aware of that date.

24 Q. Are you aware of -- from your time
25 at Boca Raton, in 2019, what was your view

1 T. CHAKURDA

2 Q. That was the one with the Google
3 analytics, do you recall seeing that?

4 A. Yes.

5 Q. Did you do analysis of the
6 Leapfrog Google analytics in coming to your
7 opinions?

8 A. No, I did not.

9 Q. Did you perform any type of
10 patient -- patient surveys in coming to your
11 conclusion?

12 A. No, I did not.

13 Q. Did you have use any
14 methodologies, scientific methodologies in
15 coming to your conclusions?

16 MS. PARKS: Objection, vague.

17 A. Again, my opinions are based on
18 almost 40 years of marketing experience and
19 my impression of the impact that D or F
20 would have on their brand.

21 Q. You cite to a lot of articles and
22 studies in your opinion. Did you read each
23 and every one of those before forming your
24 opinion?

25 A. Yes, I reviewed them.

EXHIBIT E

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

GOOD SAMARITAN MEDICAL CENTER,)
INC., et al.,)
)
Plaintiffs,)
) Case No.
v.) 9:25-CV-80526-DMM
)
THE LEAPFROG GROUP,)
)
Defendant.)
)

Videotaped Deposition of JONAH BERGER, Ph.D.

(Given Remotely)

Thursday, August 28, 2025

9:33 a.m.

Reported by: Karen Kidwell, RMR, CRR

Magna Legal Services

8 6 6 - 6 2 4 - 6 2 2 1

www.MagnaLS.com

1 exact number.

2 Q. A handful, so five or less probably? At
3 trial?

4 A. In the ballpark of five to seven. I don't
5 remember the exact number. But somewhere in the
6 ballpark of there.

7 Q. Has your expert testimony at trial ever
8 been limited by a court?

9 A. No.

10 Q. And just for clarity of record, I'm not
11 asking whether you've ever been barred as an expert
12 at court, I'm asking whether or not your testimony
13 has ever been limited by a court through a motion in
14 limine or otherwise?

15 A. I don't believe so. I'm not aware of
16 something like that.

17 Q. And I know you told me a minute ago that
18 you do not have expertise in website design.

19 Correct? You're not a web designer?

20 A. Yeah, I want to be careful. I'm not
21 putting myself forward as a person who designs
22 websites. But I do have expertise in marketing and
23 thinking about how aspects of branding, for example,
24 might shape consumers and consumer behavior. So I've
25 certainly helped companies think about those types of

1 contexts.

2 Q. Do you consider yourself to be a digital
3 low literacy expert?

4 A. I'm not sure what you mean by "digital low
5 literary."

6 Q. Sure.

7 Do you consider yourself to be an expert
8 in determining how websites should be designed in
9 order to properly provide information to low literacy
10 consumers?

11 A. I believe at some point in time I either
12 spoke to or briefly consulted for an organization
13 that thinks about those types of issues, but I myself
14 am not putting myself forward as an expert on those
15 types of issues for this particular case.

16 Q. Thank you.

17 And who retained you in this case?

18 A. What do you mean?

19 Q. Well, you have an engagement agreement in
20 this case, I assume?

21 A. Yes, it's with the plaintiffs.

22 Q. All five plaintiffs?

23 A. I -- I believe so. I'd have to go back
24 and look at the engagement, but I believe so.

25 Q. Okay. And in your own words, can you just

1 provide you with any of their own ideas about what
2 types of data might be useful?

3 A. This has been a few weeks now. I can't
4 remember every conversation that we had. But, again,
5 I want to stress that this report is my ideas. I
6 have a good degree of expertise in things like what
7 data is available online from websites, and so
8 provided direction about the types of data to look
9 for.

10 Q. In preparing your opinions, did you speak
11 to anybody directly associated with the plaintiff
12 hospitals?

13 A. I'm not sure what you mean.

14 Q. Sure. So I'm not talking about the
15 lawyers, right, and I'm not talking about the lawyers
16 at Gibson Dunn.

17 I'm asking in preparing your opinions, in
18 any sense of what that means to you, did you have
19 discussions with anyone from Good Samaritan, Delray,
20 West Boca, any of the five hospitals that are
21 plaintiffs, did you have any specific discussions
22 with them?

23 A. No, I did not.

24 Q. And I think we cleared this up earlier,
25 but I want to make sure.

1 A. I have no reason to doubt what Nicholson
2 does in his report. But I also don't feel
3 comfortable characterizing his report in one way or
4 another. And so in my report, I note in paragraph
5 77, for example, that I understand Professor
6 Nicholson finds due to the imputation methodology
7 Plaintiffs' hospital safety grades were one or two
8 grades lower than grades they would have received had
9 they participated in the survey and responded as the
10 average participating hospital does, and that is the
11 understanding I took away from the Nicholson report.

12 Q. Correct.

13 And I'm just trying make sure, Dr. Berger,
14 you don't have an opinion about whether or not these
15 hospital grades are one or two grades lower than they
16 should have been because of Leapfrog's methodology,
17 correct?

18 A. I was not asked to examine that specific
19 question in the context of this case and so I have
20 not.

21 Q. Thank you. That's all I'm trying to get
22 to.

23 A. No problem.

24 Q. I want to make sure that I understand what
25 your opinions are and what your opinions are not.

1 And so I'm not aware of any other data
2 that would be better than -- available data that
3 would be better than the data I've analyzed in my
4 supplemental report to examine this particular
5 question.

6 Q. You don't think the best data would be to
7 ask the users of the website themselves whether they
8 understand it?

9 A. No.

10 Q. And why is that?

11 A. In this instance, consumers may think they
12 understand the information, but they may not
13 actually, as I -- as I detail in my report, for
14 example, there are many pieces of information on the
15 site that may confuse consumers or make consumers
16 feel like they understand what information -- or the
17 way that things are imputed when they may not
18 actually understand it. And so given the only place
19 that I'm aware of that they could gain that
20 understanding of the methodology is this document.
21 And that's the only place they could find it.

22 Then the number of -- the percentage of
23 people, number of people that downloaded that
24 document provide a good sense of the upper bound, not
25 the absolute number, but the upper bound, a

1 conservative estimate, of the number of people who
2 could have such an understanding.

3 Q. And, Dr. Berger, is it your position
4 that -- that that document, the 16-page -- you know
5 on page 16 that you just discussed, that a reasonable
6 website user of The Leapfrog Group would understand
7 that document and they need to see that document to
8 understand their grade?

9 A. Sorry. You bring up a really good point,
10 which is I'm not sure that a reasonable website
11 visitor would be able to understand that document,
12 even if they chose to download it which most of them,
13 a huge proportion chose not to do, even if they read
14 it, I'm not sure that all of those individuals would
15 understand it. And, thus, that is even more cause
16 for concern about whether consumers actually
17 understand both the fact that -- that the minimum
18 score was used as well as how that impacts the
19 grades. But that only furthers the conclusions of my
20 report. It does not undermine them.

21 Q. Wouldn't the best way to figure out
22 whether consumers are confused or can understand the
23 information on this website to be -- to conduct a
24 consumer survey to make that determination? Or you
25 believe you, by reading articles, can determine

1 that shared the negative grades, the negative
2 hospital grades. And so that might be a place to
3 consider. I'm not saying there's only one way to
4 glean such insights or that there's one right way to
5 do it. But it's certainly possible to -- one could
6 imagine looking there.

7 Q. But you never asked any consumers -- in
8 connection with your opinions, you never interviewed
9 any consumers about their impressions or use of the
10 Leapfrog hospital safety grade website. Correct?

11 A. As we've talked about already, I have a
12 great deal of expertise in this space. I treat every
13 case differently, analyzing the issues of the case
14 and thinking about the available data. In this case,
15 given that there was good data on something like the
16 number of downloads, that seemed to be the most
17 useful type of data compared to interviewing
18 individual consumers.

19 Q. And what literature do you rely on to come
20 to the conclusion that this type of Google Analytics
21 data is good data for an expert to rely on to come to
22 his conclusions?

23 A. I'm not sure what you mean.

24 Q. Well, sure.

25 You said in your years of expertise, you

1 conveyed, where it would appear on the site, how it
2 would appear, the exact language that would be used,
3 among other things. And so without that information,
4 I can't -- I can't provide an expert -- an
5 appropriate expert answer on that question.

6 What I can say is given the reality that
7 existed and the information that was provided on the
8 website and the way in which it was provided, many
9 consumers would be unlikely to understand that TLG
10 assigns the minimum score on the imputed measures
11 based on the -- TLG's imputation disclosures.

12 Q. Understood. Let me ask it a different
13 way, then.

14 As a marketing expert, do you have an
15 opinion as to what the website would need to show in
16 order to make sure that consumers are likely to
17 understand that TLG assigns the minimum score on
18 imputed measures?

19 A. Yeah, that's not something I was asked to
20 consider in my assignment and so it's not something
21 I -- I considered here and -- or I'd need to think
22 about it more to give you a fulsome answer.

23 Q. Okay. So you don't have an opinion about
24 whether -- if the website had some bigger, bolder
25 disclaimer that said, "We are just assigning this

1 foundation. Vague. Calls for a legal
2 conclusion.

3 THE WITNESS: Okay. Thank you. I think I
4 heard both of those.

5 So I was not asked to opine on this
6 specific question. And so I would -- I would
7 need to think about it more.

8 BY MS. BLAIR:

9 Q. Okay. And going back to all of my myriad
10 of questions about focus groups and consumer surveys,
11 have you ever provided expert testimony where you
12 did, in fact, conduct a consumer survey or a focus
13 group?

14 A. I believe so, but I'd have to go back and
15 look to be sure.

16 Q. Do you have any specific recollection of
17 what that might have been?

18 A. You know, just to be clear, I often do
19 surveys in my academic research. At this point, I've
20 probably done over a thousand surveys in combination
21 of my academic and expert work. I don't -- I wasn't
22 studying this question going in so I don't know a
23 specific case offhand, but I believe I've certainly
24 used, you know, different types of methodologies in
25 different cases including things like surveys.

1 Q. And in your expert opinion -- well, strike
2 that.

3 In your academic research, why do you
4 conduct consumer surveys?

5 MS. MALONEY: Objection.

6 THE WITNESS: That's a very broad question
7 so I want to be a little bit careful. In some
8 cases, that is the best type of data that I'm
9 aware of that is available to answer a relevant
10 question. And so in cases where it is the best
11 type of data I am aware of being available to
12 answer a relevant question, it is sometimes a
13 method that I use.

14 BY MS. BLAIR:

15 Q. And what kind of cases are those cases
16 where it's the best type of data to use?

17 A. I'd have to go back and think about it
18 more and look at the specific instances.

19 Q. Do you have any recollection of using
20 consumer surveys in connection with analysis of
21 websites in any of your academic or expert research?

22 A. I've certainly done work related to
23 websites. I'd have to go back and look at the exact
24 methods used and the exact ways in which they were
25 used.

1 analyze other such sites. But regardless, even if
2 those sites did, or if those sites did not have an
3 impact on consumer perception, that doesn't change my
4 opinion that TLG's grades, D and F grades, both
5 likely impacted perceptions and hospital choice.

6 Q. Understood.

7 But you offer no opinion about how much
8 reputational damage, for example, could be
9 attributable to Leapfrog versus a one star CMS rating
10 or versus a one star patient perception rating by
11 U.S. News and World Report. Correct? You didn't do
12 that?

13 A. I was not asked to specifically quantify
14 the exact amount of reputational damage that might
15 have been attributable to one source versus the
16 other. And so I'm not putting forth an expert
17 opinion on that.

18 Q. And you're also not putting forth any
19 expert opinions about the quality of patient safety
20 at any of these five hospitals. Correct?

21 A. I'm not putting forth an opinion about the
22 actual quality of these hospitals.

23 Q. Going to page 9, same section, same
24 paragraph 22. Your report says -- and this is -- it
25 starts on the second line on page 9, that many

1 is one challenge.

2 More generally, this is a credence good
3 where even after experience, health outcomes are not
4 always indicative of quality of care. And so even if
5 I had some experience, which not everybody does, and
6 further, they -- many people only experience hospital
7 care infrequently and are unlikely to have either
8 sufficient direct or recent experience. Even if they
9 have experience, they may not be able to correctly
10 evaluate quality of care simply from health outcomes.

11 Q. And you agree with me that most hospitals
12 provide patient safety -- or I'm sorry, patient
13 satisfaction surveys to their patients, correct?

14 A. I can't speak to whether most hospitals do
15 or do not provide such surveys.

16 Q. Do you know if these five hospitals do?

17 A. I don't know offhand, no.

18 Q. And you were never told about whether they
19 do or do not provide patient satisfaction surveys?

20 A. I don't know whether they do or they do
21 not.

22 Q. Would it be important to you as an expert
23 to have reviewed those patient satisfaction surveys
24 to make the determination as to whether or not these
25 patients at these five hospitals could in fact

1 know if they exist or not.

2 A. I appreciate the question, but it's not
3 just whether such surveys existed. It's what
4 questions were asked on those surveys, the nature of
5 those questions, the potentially -- you know, when
6 those questions were asked, a variety of other
7 things. And so I can't say without more detail
8 whether such information would have been useful or
9 not.

10 Q. Right. But you would have needed to see
11 those surveys to know whether the questions on them
12 would have been helpful. Correct?

13 A. Not -- not necessarily. I asked for
14 information that was relevant to forming my opinions.
15 And I trust that I was given anything that was
16 relevant to forming my opinions.

17 Q. Did you specifically ask for patient
18 satisfaction surveys?

19 A. I asked for any information including data
20 that would be relevant to forming my opinions.

21 Q. And you asked for that information from
22 whom?

23 A. I believe I asked counsel for that
24 information.

25 Q. Okay. And so you left it up to counsel to

1 A. Yes. Correct.

2 Q. And you talk about different types of
3 ratings that could affect consumer decision making.
4 Correct?

5 A. I discuss studies that have examined and
6 shown third-party ratings and their impact on
7 consumers' choices in health care context.

8 Q. And the first bullet point is a 2022 study
9 of Yelp star ratings. Correct?

10 A. That's correct.

11 Q. Okay. And did you look at the Yelp star
12 ratings for these five hospitals in coming to your
13 opinions?

14 A. The Yelp star ratings of these hospitals
15 are not necessary to help me form my opinions.

16 Q. Okay. But my question was, did you look
17 at them?

18 A. No. Given I didn't think they were
19 relevant to understanding what TLG did, I did not --
20 did not look at them.

21 Q. But you talk about here, at least in this
22 bullet point, that this study talks about the fact
23 that patients are willing to travel 5 to 30 percent
24 further to receive care from a hospital with a higher
25 Yelp rating. Correct? That's what that bullet point

1 A. I'm not aware offhand, no.

2 Q. And so you don't have an opinion about
3 whether or not these five hospitals' low CMS star
4 rating would have an impact on whether or not
5 patients are willing to go to their hospital?
6 Correct?

7 A. I haven't analyzed that exact question.

8 Q. And the next bullet point here, it says,
9 "A 2009 study examining the effective of U.S. World
10 and News Report hospital rankings on consumer choice
11 found that a one stop drop in ranking" -- I think,
12 one spot drop; sorry, I can't read today -- "a one
13 spot drop in ranking was associated with a 6 to
14 7 percent decline in patient value."

15 Do you see that?

16 A. "In patient volume," yes, I see that.

17 Q. Okay. And as you sit here today, you have
18 no reason not to rely on that 2009 study, correct?

19 A. I'm relying on this 2009 study for exactly
20 what I cite it for. I have no reason to doubt that
21 study, but I have not gone back and looked at every
22 aspect of it.

23 Q. And are you aware as you sit here today
24 what the U.S. News rankings are for the five
25 hospitals that are plaintiffs in this litigation?

1 But there's a lot of very strong data
2 including studies in exactly this context, including
3 studies modeled directly after TLG's own hospital
4 safety grades that demonstrate the impact of such
5 grades on both consumer perceptions and consumer
6 choice.

7 Q. Okay. And you say, you continue to use
8 "likely deter," and I'm just curious whether you have
9 any empirical data about how much the difference
10 between a C and a D hospital impacts consumer
11 perception?

12 A. I wasn't asked to answer that specific
13 question. And so I did not answer that specific
14 question.

15 But I did answer the specific questions I
16 would ask -- I was asked, and that analysis leads me
17 to conclude -- leads to -- my expert opinion to
18 conclude that D and F grades deter consumers from --
19 shape -- negatively impact consumer perceptions and
20 deter consumers from choosing plaintiffs' hospitals.

21 Q. And if I look at paragraph 32 that you
22 just talked about, you rely heavily on this Duke
23 article from 2017. Correct?

24 MS. MALONEY: Objection.

25 THE WITNESS: I don't think I rely heavily

EXHIBIT F

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

-----X

GOOD SAMARITAN MEDICAL CENTER,
INC., DELRAY MEDICAL CENTER,
INC., PALM BEACH GARDENS
COMMUNITY HOSPITAL, INC. D/B/A
PALM BEACH GARDENS MEDICAL
CENTER, ST. MARY'S MEDICAL
CENTER, INC., AND WEST BOCA
MEDICAL CENTER, INC.,

Plaintiffs,

v. Case No. 9:25-cv-80526

THE LEAPFROG GROUP

Defendants.

** VIDEOTAPED DEPOSITION**

SEAN NICHOLSON, PH.D.

Monday, September 8, 2025

Reported by:

Angela M. Shaw-Crockett, CCR, CRR, RMR, CSR
Job 1395125

1 necessary for me to complete my assignment.

2 Q. Why wouldn't that have been necessary?

3 A. I was not asked to conduct an analysis of
4 Plaintiff Hospitals' quality or the programs or
5 measures that they're using to manage their quality.

6 Q. And each one of these five hospitals has
7 HCAHPS scores, correct? You saw those?

8 A. Yes.

9 Q. And so my question is, did you do anything
10 in formulating your opinions to confirm that the
11 five Plaintiff Hospitals -- any of the five
12 Plaintiff Hospitals' HCAHPS scores were accurate as
13 reported?

14 A. I didn't conduct any independent analysis.
15 In my experience, the questions are pretty standard,
16 I think, for HCAHPS. And CMS reserves the right to
17 audit those.

18 Q. So you have confidence that CMS and HCAHPS
19 responses by hospitals are accurate?

20 MR. HVIDT: Objection, form.

21 A. I didn't conduct an independent analysis
22 to conclude that. I'm just commenting that in my
23 experience, the questions that are asked of patients
24 for HCAHPS, I think, are pretty straightforward.

25

1 MR. HVIDT: Objection, form.

2 A. I assigned in my counterfactual analysis,
3 which I believe is conservative -- I assigned to the
4 nonresponders in the actual world what they would
5 have responded in the but-for world, the overall
6 mean, meaning across all hospitals that responded of
7 all different characteristics for those seven
8 variables.

9 BY MS. BLAIR:

10 Q. And when you say "what they would have
11 responded," how do you know that's how they would
12 have responded to the survey if you've not seen
13 their actual data for those measures?

14 A. Well, I'm analyzing a counterfactual to
15 come up with a defensible scenario for the
16 nonresponders responding in a way that's typical of
17 the responders. So not assigning the maximum value,
18 which a majority of responders do, but the average,
19 which is a well-established approach statistically
20 and is consistent generally with how the
21 Leapfrog Group had been conducting things.

22 Q. Wouldn't the best way to do the
23 counterfactual analysis for this litigation be to
24 figure out what these hospitals actually would have
25 scored on those four imputed metrics to show that

1 the methodology doesn't properly capture the scores
2 of nonparticipating hospitals?

3 MR. HVIDT: Objection, form.

4 A. That information is not available. That's
5 the -- that's the challenge that confronts the
6 Leapfrog Group. And they had a way of addressing
7 that prior to the fall of 2024, and they changed it
8 in the way that I show, introduced more bias, less
9 consistency than it had prior.

10 BY MS. BLAIR:

11 Q. But you have no way of knowing, as we sit
12 here today, whether these five hospitals would have
13 scored consistent with the mean had they responded
14 to the survey, correct?

15 A. Those data don't exist for me or for the
16 Leapfrog Group; therefore, the statistical question
17 of how would a principle method approach that
18 situation? And my counterfactual, in my opinion, is
19 consistent with the nonresponders responding in a
20 way that's typical of those who actually do respond.

21 Q. Is there any scientific method where a
22 nonresponding hospital should be given the same
23 score as a responsive A hospital?

24 A. You mean an A-grade hospital?

25 Q. Well, yeah. I guess I'm trying to

1 Q. Are you aware that each of these five
2 hospitals are a one- or two-star CMS hospital?

3 A. I'm aware that Dr. Harris has an exhibit
4 to that effect. I can't remember what the time
5 period is, but I'm aware at some time period that
6 was correct.

7 Q. Have you looked at the CMS data for each
8 of these five hospitals in coming to your
9 determinations or your opinions in this case?

10 A. My assignment wasn't to independently
11 evaluate the quality of the five Plaintiff
12 Hospitals, but rather, to focus on whether the
13 Leapfrog Group's method was producing reliable
14 grades that were predictive of outcomes.

15 Q. In your view as a healthcare economist, is
16 it reliable to give a hospital that has poor CMS
17 outcome scores -- to assign them the mean or average
18 score for the four imputed measures?

19 A. I think that assignment is in closer
20 keeping -- it's closer to the principles of a proper
21 system. It's closer to the principles of the
22 Leapfrog Group. And it's consistent with data that
23 I've seen that responders and nonresponders on many
24 measures are very similar.

25 Q. Well, I just read that in your report,

**IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION**

Case No. 9:25-cv-80526-DMM

GOOD SAMARITAN MEDICAL CENTER,
INC., et al.,

Plaintiffs,
v.

THE LEAPFROG GROUP,

Defendant.

**[PROPOSED] ORDER GRANTING THE LEAPFROG GROUP'S
MOTION TO EXCLUDE THE PLAINTIFFS' EXPERT WITNESSES**

This matter comes before the Court on Defendant Leapfrog Group's Motion to Exclude Plaintiffs' Expert Testimony. The Court, having reviewed the Motion, any response thereto, and all available evidence, hereby GRANTS the Leapfrog Group's Motion. Accordingly, it is hereby ORDERED and ADJUDGED that:

1. Plaintiffs' proffered expert witness Mr. Thomas Chakurda is excluded from testifying at any trial in this matter because Mr. Chakurda's two opinions do not assist the trier of fact to determine a material issue of fact and are not based on sufficient facts or data.
 - a. The Court holds that Mr. Chakurda's putative expert opinions are not "helpful" as required by Fed. R. Evid. 702 and *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), because Mr. Chakurda's opinions do not help the trier of fact understand material issues of fact in this matter. "[E]xpert testimony is admissible if it concerns matters that are beyond the understanding of the average lay person. Proffered expert testimony generally will not help the trier of fact when it offers nothing more than what lawyers for the parties can

argue in closing arguments.” *Cook ex rel. Estate of Tessier v. Sheriff of Monroe County, Fla.*, 402 F.3d 1092, 1111 (11th Cir. 2005) (quoting *U.S. v. Frazier*, 387 F.3d 1244, 1262-63 (11th Cir. 2004) (en banc)). Mr. Chakurda’s opinions are accessible and readily understood by an average lay person, and his testimony focuses on undisputed facts, irrelevant facts, or general concepts that do not require scientific, technical, or other specialized knowledge. Mr. Chakurda’s opinion is irrelevant, unhelpful, and unreliable.

- b. The Court holds that Mr. Chakurda’s opinions are not based on a reliable methodology applied to sufficient facts or data and are inadmissible under Fed. R. Evid. 702 and *Daubert*. “Reliability of the methodology requires an exacting analysis of the proffered expert’s methodology.” *Banuchi v. City of Homestead*, 606 F. Supp. 3d 1262, 1269 (S.D. Fla. 2022) (internal quotation omitted). One of the key factors in testing reliability is “whether the expert’s methodology can be, and has been, tested.” *Id.* Mr. Chakurda’s opinions are irrelevant, unhelpful, and unreliable because he did not conduct any studies or consumer surveys, analyze any data, or review any marketing plans, and instead relied only on his “impression” of the facts and his “marketing experience.” This is not a testable methodology.

2. Plaintiffs’ proffered expert witness Dr. Jonah Berger is excluded from testifying to his three opinions at any trial in this matter because Dr. Berger’s opinions do not assist the trier of fact to understand the evidence or determine a material issue of fact, and are not based on sufficient facts or data.

- a. Dr. Berger's first opinion is that Leapfrog's "D" or "F" Safety Grades for Plaintiff Hospitals *likely* impact consumer perceptions of Plaintiffs and deter customers from choosing to receiving care there. The Court holds that Dr. Berger's first opinion is inadmissible under Fed. R. Evid. 702 and *Daubert* because his proffered testimony does not concern matters outside of the understanding of the average lay person, does not rely on any sufficient facts or data, nor does it employ any reliable methodology. The average lay person with any level of schooling generally understands that "D" and "F" are negative grades. To the extent it goes beyond that, Dr. Berger's report is speculation untethered to data. Dr. Berger's opinion is therefore unhelpful and unreliable.
- b. Dr. Berger's second opinion is that if Leapfrog continues to publish "D" or "F" Safety Grades for Plaintiff Hospitals, it is *likely* to amplify effects of impacting consumer perceptions. The Court holds that Dr. Berger's second opinion is inadmissible under Fed. R. Evid. 702 and *Daubert* because Dr. Berger's opinion does not concern matters outside of the understanding of the average lay person and does not rely on sufficient facts or data or any reliable methodology to assess patient admissions and revenue. Again, the average lay person understands that "D" and "F" are negative grades, and Dr. Berger's report is, beyond that, speculation. Dr. Berger's opinion is unhelpful and unreliable.
- c. Dr. Berger's third opinion is that consumers are unlikely to understand that Leapfrog imputes minimum possible scores on the imputed measures because consumers are unlikely to see Leapfrog's Spring 2025 Scoring Methodology Document. The Court holds that Dr. Berger's third opinion is inadmissible

under Fed. R. Evid. 702 and *Daubert* because (1) Dr. Berger is not qualified to opine on website design or digital literacy, (2) Dr. Berger's opinion does not rely on sufficient facts or data from the Plaintiff Hospitals or any reliable methodology to assess purported deception of patients, but instead speculates based on his own viewing of the website, and (3) Dr. Berger's report does not address the material issues or go beyond what the lawyers for the parties can argue. Dr. Berger's opinion is unhelpful and unreliable.

3. Plaintiffs' proffered expert witness Dr. Sean Nicholson is excluded from testifying at any trial in this matter because Dr. Nicholson's opinions are not based on sufficient facts or data or reflect a reliable application of a methodology.

- a. Dr. Nicholson opines that Leapfrog's hospital grades are far from reliable or transparent, and that TLG's methodology departs from guiding principles for how hospital quality or safety should be measured. Dr. Nicholson's opinions are not tethered to actual facts or data regarding Plaintiffs. Dr. Nicholson admitted that he did not use actual information about the Plaintiff hospitals to calculate his own grades for them because that information was not available. He ignored the data that was available, such as CMS ratings, and instead assumed the Plaintiff hospitals were entitled to average grades. The Court holds that Dr. Nicholson's opinions are inadmissible under Fed. R. Evid. 702 and *Daubert* because Dr. Nicholson's opinions do not rely on sufficient facts or data from the Plaintiff Hospitals. Dr. Nicholson's opinions are unhelpful and unreliable.

DONE AND ORDERED in the Southern District of Florida on [].

DATE: _____

Donald M. Middlebrooks
United States District Judge