

**Working Paper**

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**Title:**

**Safety Net Hospital Financial Performance in 2010**

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## **Abstract**

### **Safety Net Hospital Financial Performance in 2010**

This research explores a newly accessible source of audited financial statements to develop a data base that describes the financial condition of a nationally representative sample of 98 large, urban, predominantly publicly-owned safety-net health systems in 2010. Traditional financial ratios describe system financial performance; detailed information from statement footnotes allows an exploration of the costs of free care and Medicaid payment shortfalls relative to subsidies received from local governments and Medicare and Medicaid supplemental payments including Disproportionate Share Hospital (DSH) payments.

We found that most systems achieved a fragile financial health that is highly dependent on local government subsidies and Medicaid supplements. The Patient Protection and Affordable Care Act of 2010 (ACA) legislates reductions in Medicaid supplemental payments and recommends directing payments to fewer safety net hospitals. Local government subsidies may also be diverted from safety net systems to support the cost of Medicaid expansions established in the ACA. How subsidies change and how these providers respond over the next few years will have major implications for access to health care for low-income populations, particularly the estimated 23 million people who would remain uninsured even with the full implementation of the Affordable Care Act, for those with long-term mental illnesses, and for potentially millions more left uninsured by states declining to participate in the Act's expanded Medicaid eligibility provisions.

Key Words: safety net; financial performance; Affordable Care Act

## **Introduction**

Safety net hospitals, which serve a disproportionately large share of low-income populations, face enormous opportunities as well as critical challenges as the Affordable Care Act of 2010 proceeds toward full implementation (Kane, Singer, Clark, Eeckloo, & Valentine, 2012). Large urban publicly owned safety net hospitals have been essential safety net providers in a country with close to 50 million uninsured people and major chronic diseases, especially mental illness, still poorly served by the private sector. This research, using newly accessible audited financial statements of publicly-owned health systems, describes the financial health of a sample of large urban, predominantly public hospitals in the year 2010, and analyzes the potential impact of key provisions in the ACA affecting these providers.

## **Population and Data Sources**

We identified our sample using hospital ownership, location (urban/rural), and size (150 beds or higher) to identify them in the American Hospital Directory (AHD.com) data base. Our search yielded 159 large urban publicly-owned hospitals in 30 states.

Detailed financial information for these hospitals was obtained from the central municipal repository where all issuers of municipal debt ([www.nsr.bemma.org](http://www.nsr.bemma.org)) are now required to file audited financial statements annually. When not available through the repository we asked for statements directly from health systems. Our search benefited from 2008 Securities and Exchange Commission regulations establishing free and instant access to electronic filings of all municipal debt issuers starting in July 2009 (SEC, 2008).

Of the 159 public hospitals identified, we were able to obtain 2009-2010 audited financial statements for 95 hospitals within 83 health systems. To increase the regional representativeness of our sample, we added 15 large private nonprofit urban health systems with very high Medicaid inpatient utilization as well as high free care percentage of cost. Five of the 15 nonprofit systems had converted from public ownership. Ten others had high safety net metrics and were located in regions for which we had low public hospital representation. With these fifteen private nonprofit health systems our sample rose to 110 safety net hospitals in 98 systems. The audited financial statements consolidated information for all hospitals in the health system, so our final sample included 183 hospitals, of which 73 were not large urban safety net hospitals.

The regional distribution of the 98 safety net health systems in our sample was fairly close to that of the 159 hospital original population, except that the West was underrepresented in our sample. The distribution of hospitals was less representative of both the South Central and West, while overly representative of the South Atlantic regions, because the South Atlantic region averaged more hospitals in their systems. Table 1 describes the regional ownership distribution of the original population of 159 individual publicly-owned hospitals and compares it to the regional distribution of the sample population of systems and hospitals.

(Insert Table 1 here)

These 98 health systems reported roughly \$5.5 billion in charity care costs, and another \$2.7 billion in bad debt cost in 2010, representing 11.8% of aggregate operating expenses.

Data from audited financial statements was combined with Medicaid payer mix information from the American Hospital Directory (based on Medicare Cost Reports) and CMS annual reports on Medicaid and Medicare Disproportionate Share Payments (CMS, 2009a and CMS, 2009b) to form the basis of our analysis. Lacking more current sources, we merged older data (Medicare DSH payments, Medicaid payment to cost ratios) with 2010 recent audited financial data. One assumption underlying our use of these data is that the values do not change dramatically over 1 – 3 years of time

## **Methods**

Three types of performance measures were calculated: Financial Ratios, Safety-Net Costs, and Safety-Net Revenue Offsets.

### Financial Ratios

Seven financial ratios were used to describe the financial performance of each health system. The method of calculation and the meaning are described in Table 2.

(Insert Table 2 here)

### Safety Net Costs

Two safety net cost types were collected at the hospital level, then aggregated to the health system level for multihospital systems. The first was “free care”, care provided to patients deemed eligible for free or discounted care based on the health system’s internal policies. When free care was reported at charges, that figure was divided by the markup (see Financial Ratios, above) to arrive at an estimate of free care cost.

The second major safety net cost was the Medicaid shortfall, or the difference between the average cost to provide services to Medicaid patients, and payments for that care that are made under traditional payment mechanisms (fee for service and managed care) before supplemental payments. Table 3 describes the variables used to calculate the Medicaid shortfall and the data sources used.

Not included in these calculations are the costs of care for patients in local indigent care programs. Thus safety net cost may be understated.

(Insert Table 3 here)

### Safety Net Revenue Offsets

Three major sources of payments received by safety net providers were intended to offset safety net costs. First were Medicare Disproportionate Share (DSH) payments, downloaded from a CMS website (CMS, 2009b). Due to missing 2010 values, we used the 2009 Medicare DSH values to approximate the value in 2010. The second were Medicaid supplemental payments, disclosed in the audited financial statements for 63 of our 98 hospital systems. These included disproportionate share as well as upper-payment-limit and other Medicaid-based supplemental payments. Generally these payments were reported net of provider assessments transferred to the state for matching purposes, although not all systems disclosed this information. The third payment source was local government subsidies, generally from local property and sales taxes.

This was a first-time effort to identify health system-reported measures of Medicaid supplemental payments from audited financial statements. Such payments are estimated by management at levels expected to be received/retained. Unfortunately there is no reliable and current national source of Medicaid supplemental final payments to health systems with which to evaluate the accuracy of the data reported in audited statements. The results should be considered with this caveat in mind.

Table 4 describes the three payment sources and where the data was found.

(Insert Table 4 here)

The ratio of safety-net revenue offsets to safety net costs was created by summing the three revenue offset sources for the numerator, and the two safety net cost sources for the denominator. We were only able to calculate this ratio for the 63 hospital systems reporting Medicaid supplemental payments.

## **Findings**

### *Overall Financial Performance of Safety Net Hospitals, 2009 and 2010*

Standard ratio analysis (see Table 5) indicated a moderately financially healthy picture of our sample in aggregate. The most favorable financial results were plant age and capital expenditure ratios, which were close to the Fitch median 2010 values for all 248 Fitch-rated hospitals and health systems (Fitch Ratings, 2011). Median total margins and days cash on hand fell between the lowest Fitch rating needed to qualify as investment grade (BBB) and the median of all of Fitch's ratings. The weakest results were the operating margins, equity financing, and cash flow total debt ratios, which were close to the median for Fitch BBB ratings.

Between 2009 and 2010, most ratios show no change or slight improvements. Median profitability was low but positive, liquidity was reasonable, and solvency appeared sustainable. While three or four systems were in fairly dire financial condition (negative net worth, large operating losses), most were in a sustainable position as of 2010.

(Insert Table 5 here)

The aggregate statement of changes in net assets (combination of “income statement” and “other changes in net assets”), combining all systems by year, is displayed in Table 6. Net patient service revenues represented 84% of total operating revenue, while capitation revenues were 6%, and local government subsidies another 5.8% of total operating revenues. Other operating revenues (parking, cafeteria, grants) generated 4% of operating revenues.

(Insert Table 6 here)

Capitation revenues were reported by only 13 health systems, of which 9 were affiliated with an independently licensed Medicaid managed care plan. Five more systems had affiliated licensed Medicaid managed care plans, but reported no capitation revenue. While there were likely to be other Medicaid managed care plans contracting with our sample hospitals, they were not affiliated to the hospitals through legal or common control means. Being affiliated with a Medicaid HMO plan had no statistically significant impact on the system’s financial health.

Nonoperating revenues (mostly investment income) generated between a third (in 2009) and half (in 2010) of total surplus. Nearly eighty percent of the \$600 million improvement in the total surplus in 2010 over 2009 was due to improvements in the market value of investments that were sold: “realized gains/losses” went from a net loss over \$270 million in 2009 to a gain of over \$208 million in 2010. Unrealized gains (improvements in the value of investments that were held, not sold, over the reporting period) were also a significant source of positive financial performance, generating over \$600 million in both years. However these represent changes in the market value of securities that have not been sold so the changes could reverse in future years.

Operating income, which comes from providing services to patients, constituted only 32% of the total change in net assets in 2010 (48% in 2009 when realized losses were incurred on investment trading).

Slightly over a quarter of our sample systems bore significant financial risk related to future obligations associated with their pension and post-retirement health benefit obligations. Net assets (net worth or equity) was reduced by over \$550 million due to charges related to unfunded pension liabilities in the two years combined, representing 38% of those systems’ total surplus generated. At least twenty of the health systems reported obligations for underfunded defined benefit pension plans and future obligations for post-retirement benefits that equaled or exceeded 5% of their net assets (range: 5% to 224% of net worth). Another nine reported significant post-retirement employee benefit obligations.

Another pension-related risk identified was optimistic assumptions about the long-term rates of return on pension fund assets, which may understate the unfunded obligations. For the systems with defined benefit pension obligations, the assumed long-term rates of return on investment ranged from 7 – 9%. However actual experience for public pension plans has been 5.7% since 2000.(Walsh, 2012).

A final consideration of financial sustainability was the level of capital spending to maintain property, plant, and equipment, including large information technology infrastructure. Combined capital expenditures for our sample totaled \$9.8 billion, or roughly 139% of aggregate depreciation expense for the two years. This level of capital spending was adequate to assure maintenance of a reasonable plant

age but may not be enough to cover significant new capital needs such as IT infrastructure or major equipment or building upgrades.

### *Safety Net Costs and Related Revenue Offsets*

An overview of the 2010 safety net costs and the revenue offsets (see definitions in Tables 3 and 4) for the 63 systems reporting Medicaid DSH is presented in Table 7. The aggregate safety net revenue offset of \$7.7 billion dollars for these 63 health systems far exceeded the Total Surplus of all 98 systems in 2010 (roughly \$2 billion; see Table 6). If the safety net costs remained but the revenue “offsets” were significantly reduced or eliminated in the future, this group of hospitals would be hard-pressed to remain profitable.

(Insert Table 7 here)

Overall, free care represented 60% and the Medicaid shortfall was 40% of the total safety net “cost”. These costs were fully offset by the combined revenue offsets: Medicaid supplemental payments (46%), local government subsidies (43%), and Medicare DSH (10%).

However there is substantial variation in the payment to cost ratios within the 63 systems. The bottom quartile had a safety net ratio (revenue offset/cost) of only 0.68. Roughly half of the systems had safety net ratios below 1. On the other hand, the top quartile of systems had safety net ratios above 1.33.

### **Discussion**

If the Affordable Care Act (ACA) is fully implemented according to the timetable presented in the law, the country should experience a significant reduction in number of uninsured over time, from around 50 million uninsured in 2010 to 22 million over time, starting in 2014. Increased coverage presents both risks and opportunities for the nation’s safety net providers. Their ability to attract/retain their patient populations is a key risk; success will depend on how attractive they remain to patients in terms of care and convenience, whether they are offered in subsidized and Medicaid networks, and how competitive their marketplace is for the newly insured patients(Katz, 2011).

At least two major financial issues are also critical to safety net system viability. One is whether there will be funding for those who remain uninsured, as these populations are likely to continue to use large urban publicly-owned hospitals and other traditional safety-net systems. Roughly 23 million people were expected to remain uninsured, representing undocumented immigrants (22%) , people eligible but not enrolled in Medicaid or the Children’s Health Insurance Program (40%), those with affordability exemptions (13%), those able to afford coverage but not buy it (12%) , and those eligible for a subsidized option who do not take it (6%). Roughly half of the 23 million uninsured would have incomes below 138% of Federal Poverty Levels, and 85% would be living in metropolitan areas(Buettgens & Hall, 2011).

With the Supreme Court granting states permission to not expand Medicaid eligibility, additional millions of low-income adults may remain uninsured. In the 24 states that have not expanded Medicaid coverage as of March 2014 are nearly 5 million people with incomes below 100% of the federal poverty

line who are likely to remain uninsured (KFF, 2014) It is likely that a large share of these millions will be disproportionately served by safety-net providers.

As the ACA provisions stand today, much of the continued funding for the uninsured will need to be provided by state and local government. ACA provisions reduce Medicare DSH by \$22 billion and Medicaid DSH by \$14 billion over the period 2014 - 2019 (AHA, 2014; Mitchell, 2013) with the greatest cuts coming in the later years. The remaining Medicare and Medicaid DSH would be “retargeted” to states providing high levels of care to the uninsured.

As our analysis shows, local government funding for the uninsured was 43% of total safety net revenue offsets; if charity care is cut in half, local government funding could come close to covering the remaining charity care in the aggregate. However the willingness of local property owners to continue to fund a public hospital serving a large population of undocumented immigrants or nondisabled childless adults may become politically difficult, especially if the more socially attractive low-income patient populations become insured.

Another financial risk faces the safety net systems that successfully retain their low-income insured populations. They are at risk for potentially low rates paid by Medicaid and subsidized private insurance. For instance, Boston Medical Center experienced a reduction of Medicaid FFS rates to roughly 80% of their former levels relative to cost. The rates dropped from 71% of cost (before supplements) in 2006 to 56% of cost (before supplements) in 2010. Some of this was due to recession-related budget cuts. However supplemental payments also went down, from \$120 million in 2006 to only \$32 million in 2010, as they were redirected into insurance subsidies (Boston Medical Center, 2009).

If the Medicaid payment to cost percentages for our 63-system sample dropped to 80% of the levels in our 2010 analysis in Table 7, the Medicaid shortfall for those systems would grow almost 60%, from 2.7 billion to \$4.3 billion, and the aggregate ratio of revenue offsets/safety net costs would drop to 0.91 (mean 0.89, and median 0.78), assuming no change in free care costs. Aggregate free care costs would have to decrease by 38% (and be replaced by patients paying at least at the level of their costs) for the systems to “break even” from such Medicaid rate reductions. But the newly privately-insured patients might also represent rates below cost, so safety net hospitals will not necessarily do better with more privately insured patients. They could do a lot worse if their Medicaid supplemental payments and/or local government subsidies were reduced, even with the same number of low-income patients.

This is a first-time effort to develop a financial profile of major urban, predominantly public safety –net health systems in the U.S. using audited financial statements. Audited financial systems are rich in detail, but their measurements are not standardized and the underlying elements are subject to managerial discretion. Thus our snapshot is not as sharp a picture as we might wish, but there are no other national data sources providing the key variables of our analysis for these hospitals.

Despite these limitations, we believe our findings are a fair depiction of the financial condition of a large share of the major urban, predominantly public safety net providers in the US. The system level financial



performance presents a rarely-explored picture of the aggregate condition of these providers and sets a baseline for analysis of the impact of the ACA as it is implemented in the coming years.

Clearly safety net systems have a lot to lose under universal coverage. It remains to be seen whether they have a lot to gain. It will be critical for federal, state, and local health authorities to carefully model the impact of health plan network design, plan payment levels, and the re-allocation of discretionary safety net subsidies as the country progresses toward universal coverage in this country. Safety net institutions will be needed in many local markets with their special expertise and services tailored to the needs of low-income populations. But they are currently financed by a patchwork of mechanisms that have never been fully transparent, coordinated, or comprehensive. Greater transparency is essential, as is great caution in tinkering with financing policies made at local, state, and federal levels by policymakers with potentially conflicting priorities.

**Table 1**  
**Distribution of Hospitals/Systems by Region**

	Midwest	Northeast	South Atlantic	South Central	West
Original Public Hospital List (n=159 hospitals)	11%	9%	11%	42%	27%
Final Sample (n=98 systems)	15%	8%	15%	45%	17%
Final Sample (n=183 hospitals)	14%	10%	28%	35%	13%
Average # hospitals/system	2	2.4	3.4	1.5	1.4

**Table 2**

## Calculation of Financial Performance Ratios

<b>Variable</b>	<b>Calculation</b>	<b>Meaning</b>
<b>Markup Ratio</b>	(Gross patient service revenue plus other operating revenue)/total operating expense	Measures the overall relationship between charges (prices) and costs. Used to estimate the cost of free care and bad debt when valued at charges
<b>Total Margin</b>	Excess of Revenue over Expense/(Operating Revenue plus Nonoperating Revenue)	Measures the combined profitability of operations (patient care activities) and nonoperating sources (mostly investment activities ). Higher is more financially favorable.
<b>Operating Margin</b>	Operating Income/Total Operating Revenue	Measures the profitability of operations only , Higher is more financially favorable
<b>Days Cash on Hand</b>	(Current and Noncurrent Cash and Board-Designated or Unrestricted Investments)/((total operating expense minus depreciation expense)/365)	Measures the ability of the organization to meet its payroll and other short-term liabilities; higher days cash on hand is more financially favorable.
<b>Equity Financing Ratio</b>	Unrestricted Net Assets/Total Unrestricted Assets	Measures the ability of the organization to maintain a sustainable mix of financing sources (equity versus debt); higher is more financially favorable.
<b>Cash Flow to Total Debt</b>	(Excess Revenue Over Expenses plus Depreciation Expense)/Total Debt	Measures the ability of the organization to repay its debts with cash from operations; higher is more financially favorable.
<b>Plant Age</b>	Accumulated Depreciation/Depreciation Expense	Measure of the average age of property, plant and equipment; lower is more financially favorable.

**Table 3**

**Variables Involved in Calculating Medicaid Shortfall**

<b>Medicaid Cost</b>	Medicaid 2010 % Gross Patient Service Revenue/ 2010 Total Operating Expense	Medicaid % GPSR from AHD.com Total operating expense from Audited Financial Statements
<b>Medicaid Payment</b>	Medicaid Cost * Hospital-specific payment to cost ratio from 2007	Hospital-Specific Payment to Cost Ratio obtained from CMS (CMS, 2009a)(Medicaid FFS payments plus Medicaid MCO payments)/Medicaid Cost in 2007
<b>Medicaid shortfall</b>	Medicaid Payment – Medicaid Cost	Calculated

**Table 4**  
**Safety Net Revenue Offsets**

<b>Medicaid Supplements</b>	Combine Medicaid DSH, UPL, and other supplemental payments, minus provider taxes and IGT transfers reported by the system	Audited Financial Statements, usually in footnotes, sometimes on Statement of Operations (63 hospital systems reported Medicaid supplemental payments)
<b>Medicare DSH</b>	2009 Medicare DSH * 1.027 (the increase in Medicare total hospital expenditures 2010 over 2009)	2009 hospital-specific Medicare DSH from CMS web site (CMS, 2009b)
<b>Local Government Subsidies</b>	As reported , generally lump-sum amounts paid to hospital and funded by property, sales taxes	Audited Financial Statements



**Table 5**  
**Key Financial Performance Measures of Safety Net Systems**

	2010 (N=98)				2009 (n=95)				2010 Urban Hospitals (Ingenix, 2012)	Fitch 2010 Median Values <sup>1</sup>	Fitch BBB 2010 Median Values
	Mean	25 <sup>th</sup>	50 <sup>th</sup>	75 <sup>th</sup>	Mean	25 <sup>th</sup>	50 <sup>th</sup>	75 <sup>th</sup>	50 <sup>th</sup>	50 <sup>th</sup>	50 <sup>th</sup>
<b>Ratio:</b>											
<b>Total Margin</b>	.031	0.001	<b>0.032</b>	0.061	0.028	0.0002	<b>0.031</b>	0.064	<b>.042</b>	<b>0.039</b>	<b>0.030</b>
<b>Operating Margin</b>	.019	-0.003	<b>0.017</b>	0.045	0.020	0.0011	<b>0.0183</b>	0.0493	n/a	<b>0.026</b>	<b>0.017</b>
<b>Days Cash on Hand</b>	153	69	<b>140</b>	209	147	72	<b>132</b>	208	<b>113</b>	<b>180.5</b>	<b>128.6</b>
<b>Equity Financing</b>	0.47	0.36	<b>0.51</b>	0.63	0.48	0.38	<b>0.49</b>	0.60	<b>.50</b>	<b>0.58</b>	<b>0.52</b>
<b>Cash Flow to Total Debt</b>	0.22	0.089	<b>0.144</b>	0.253	0.167	0.086	<b>0.154</b>	0.248	<b>.195</b>	<b>0.19</b>	<b>0.16</b>
<b>Plant Age</b>	10.3	8.6	<b>10.2</b>	12.0	10.2	8.5	<b>10.1</b>	11.4	<b>10.26</b>	<b>10.2</b>	<b>10.5</b>
<b>Capital expenditure/ Depreciation Expense</b>	1.35	0.83	<b>1.15</b>	1.45	1.43	0.87	<b>1.18</b>	1.58	n/a	<b>1.16</b>	<b>1.08</b>

**Table 6**  
**Aggregate Statement of Changes in Net Assets**

	2010 (\$000)	2009 (\$000)
Net Patient Service Revenue	\$59,763,894	\$55,078,447
Capitation revenue	\$4,424,655	\$4,075,179
Government subsidies for operations	\$4,138,775	\$3,827,287
Other Operating Revenue	\$3,110,278	\$2,725,412
<b>Total Operating Revenue</b>	<b>\$71,413,692</b>	<b>\$65,682,159</b>
Depreciation	\$3,565,769	\$3,307,346
Interest	\$991,798	\$899,756
Other operating expenses	\$65,937,990	\$60,609,707
<b>Total operating expenses</b>	<b>\$70,495,557</b>	<b>\$64,816,809</b>
<b>Operating Income</b>	<b>\$918,135</b>	<b>\$864,528</b>
Interest and dividends	\$474,410	\$440,529
Realized Gains/losses on sales of securities	\$208,925	-\$271,940
Total investment income	\$894,615	\$309,530
Gains/losses on asset sales/equity investments	\$10,907	\$17,394
Permanent impairments/asset writedowns	-\$42,013	\$24,027
Other nonoperating revenues (gifts, bequests)	\$102,512	\$94,787
<b>Total nonoperating revenue</b>	<b>\$966,021</b>	<b>\$445,738</b>
<b>Excess of revenue over expenses</b>	<b>\$1,884,156</b>	<b>\$1,310,266</b>
OTHER GAINS (LOSSES) DUE TO		
Extraordinary Gains (Losses)	\$107,781	\$12,421
<b>Total Surplus/Deficit</b>	<b>\$1,991,937</b>	<b>\$1,322,687</b>
Other Changes in Net Assets:		
Net assets released from restrictions – capital	\$571,232	\$543,031
Unrealized gains (losses) on investments	\$680,481	\$636,230
Minimum pension liability adjustment	-\$194,293	-\$356,971
Transfers from (to) affiliates	-\$99,094	-\$73,423
Other Changes	-\$61,574	-\$166,959
<b>Total Change in Unrestricted Net Assets</b>	<b>\$2,928,671</b>	<b>\$1,919,519</b>
Capital Expenditures	\$4,931,958	\$4,838,731



**Table 7**  
**Safety Net Costs and Revenue Offsets, 63 Health Systems Reporting, 2010**

Safety Net "Cost" (\$000)			Safety Net Revenue Offsets: (\$000)				Ratio of Revenue Offset/Cost	
Medicaid Shortfall	Free care at cost	Total Safety Net Cost	Medicare DSH	Medicaid DSH, UPL, Other Supp	Local Government Subsidies	Total Safety Net Revenue Offsets	Aggregate	Mean
2,765,363	4,139,140	6,904,503	777,425	3,618,181	3,335,396	7,731,002	1.12	1.17
40%	60%		10%	47%	43%			

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