

## An Evaluation of the Financial Health of the St. Charles Health System

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### I. BACKGROUND AND ASSIGNMENT

As part of ongoing negotiations with the St. Charles Health System (SCHS), Service Employees International Union (SEIU) Local 49 asked ECONorthwest to provide an independent evaluation of SCHS's financial health. Specifically, we were asked to address the following questions:

- How has SCHS described its economic condition and prospects in recent months?
- What criteria do analysts use to determine if a hospital or hospital system is financial troubled? Using these criteria, how has SCHS performed in recent years?
- Looking forward, what are SCHS's prospects? Will health care reform adversely affect SCHS?
- How would an annual raise of 3.5% for SEIU-represented employees affect SCHS's financial health?

Briefly, while SCHS suggests that it is struggling financially, our analysis of common indicators of hospital performance suggest otherwise. SCHS is profitable, and its profitability was in line with recommended benchmarks. In light of this and other performance indicators, Moody's Investors Service (a bond rating

agency) upgraded its outlook from stable to positive only one year ago.

Looking forward, we do not see any imminent threats that will weaken SCHS's performance. SCHS is the dominant provider in an industry and a region that are both expected to grow in the future.

Providing an annual raise of 3.5 percent to the 600 workers represented by SEIU is unlikely to significantly impact SCHS's financial performance. A raise of this magnitude would cost approximately \$525,000 in the first year and would add approximately \$1.6 million to costs by the third year. To help place these values in context, \$525,000 is one-tenth of one percent of SCHS's 2010 operating revenue and is less than SCHS paid its CEO in 2010. \$1.6 million is approximately three-tenths of one percent of SCHS's 2010 operating revenue and less than the amount paid to the top four SCHS executives in 2010.

## II. HOW HAS THE HOSPITAL DESCRIBED ITS ECONOMIC CONDITION AND PROSPECTS IN RECENT MONTHS?

*St. Charles Health System (SCHS) suggests that its financial health is poor, that its recent performance has fallen short of expectations, and that its recent declines are harbingers of future weakness; however, earlier in 2011, in its annual disclosure report to bondholders, SCHS described its financial performance as “solid.”*

In presentations to SEIU and in various media reports, the St. Charles Health System (SCHS) suggests that it is financially troubled. For instance, an August 3rd article in the *Bend Bulletin* reported that SCHS laid off workers, described the SCHS’s financial performance as “poor,” and noted that the SCHS had lost money through the first half of 2011.<sup>i</sup>

In its most recent presentation to SEIU, SCHS emphasized that 2011 revenues and profits had (through August) fallen short of budget expectations. While SCHS budgeted for \$350 million in operating revenue and nearly \$12 million in operating income (or a 3.4 percent operating margin), it earned \$341 million in operating revenue and \$5.5 million in operating income (a 1.6 percent operating margin) through August 2011.<sup>ii</sup>

SCHS attributes its self-described “weak” performance to a decline in the share of its patients covered by commercial insurance. Commercially insured patients reimburse hospitals at higher rates than

patients insured by Medicare and Medicaid, and the share of SCHS patients with commercial insurance declined from 31.7 percent in 2010 to 28.9 percent in 2011 (through August).<sup>iii</sup>

Furthermore, SCHS views this change as a harbinger of things to come. SCHS expects the gap in reimbursement rates between commercial insurance providers and Medicare and Medicaid to grow due to cuts to both government programs. SCHS also expects that health care reforms will continue to reduce the share of its patients with commercial insurance.

Pointing to these factors, SCHS argues that its condition and prospects are poor and that SEIU’s wage proposals are not sustainable.<sup>iv</sup> However, while SCHS has recently described its performance as “poor,” earlier in 2011, in its FY2010 Annual Disclosure Report to bondholders, SCHS referenced its “solid financial performance” and “stable operating results.”<sup>v</sup>

### III. BASED ON COMMON INDICATORS OF FINANCIAL PERFORMANCE, IS SCHS FINANCIALLY TROUBLED?

*No. SCHS is not financially troubled. Troubled or unhealthy hospitals earn insufficient income to finance the investment required to maintain and grow their business, are vulnerable to shocks, and struggle to pay their debts. Recent financial data produced by SCHS does not suggest that it faces any of these problems. In particular, SCHS is profitable. Its operating margin over the period January 2009-August 2011 exceeds the 3 percent threshold that analysts frequently use to evaluate hospital financial health.*

SCHS's description of its financial health is incomplete. Assessing a hospital's (or hospital system's) financial health requires more than a comparison of financial performance relative to budget expectations for part of a fiscal year. Failure to meet budget expectations is not sufficient to support the conclusion that a hospital is troubled. A hospital that fails to meet budget expectations could be struggling or it could have had unrealistic budget expectations. Furthermore, hospitals that fall short of expectations could still perform well. For instance, one would not conclude that a world-class athlete is unhealthy simply because she did not win the gold-medal she expected to win.

Hospital performance has many dimensions and these can (and will) fluctuate over time. As a result, analysts typically assess hospital financial health by asking a number of questions about the hospital's performance and looking at

data that helps answer these questions over a several year time horizon. For instance, Moody's Investors Service, a bond rating agency, examines trends in dozens of financial indicators when making its bond rating determinations that help determine the interest rates at which hospitals borrow money.

When assessing hospital performance, the first question analysts typically ask is: "is the hospital earning a profit, or do its revenues exceed its costs?" Most often, analysts focus on the subset of revenues and costs associated with hospital operations (e.g., patient care, gift shops, cafeterias, etc.) – its operating income.<sup>vi</sup>

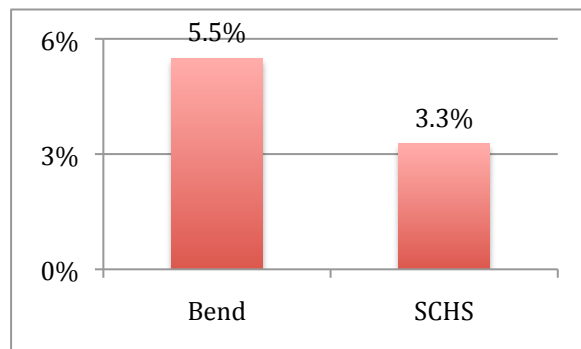
Hospitals whose operating expenses exceed their operating revenues must use cash reserves or loans to cover the shortfall. Such solutions may solve the problem in short-run; however, hospitals whose expenses persistently exceed their earnings will have difficulty surviving.

A healthy hospital requires more than just a positive operating margin. An article in *Health Affairs* defines "a financially 'healthy' organization [as] one that is producing an operating margin sufficient to finance the current and future capital that is required for the maintenance and growth of its business."<sup>vii</sup> Hospital analysts frequently suggest that healthy hospitals earn a 3 percent operating margin (i.e., the hospital keeps 3 cents of every dollar of operating revenue earned by the hospital) to finance its current and future capital needs.

For instance, the Oregon Office for Health Policy and Research suggests that healthy hospitals have an operating margin in the 3-5 percent range.<sup>viii</sup> The median hospital given an A rating (upper medium grade

and subject to low credit risk) by Moody's Investor Service in 2010 earned an operating margin of 2.6 percent.<sup>ix</sup> Alternatively, the Health Care Financial Management Association recommends different benchmarks for for-profit and not-for-profit hospitals. They recommend that for-profit hospitals have operating margins between 8 and 13 percent and non-profits have operating margins between -1.86 and 3 percent.<sup>x</sup>

**Figure 1. Average Operating Margin for St. Charles-Bend and SCHS, 2009-2011 (through August)**



Source: ECONorthwest analysis of audited financial data.

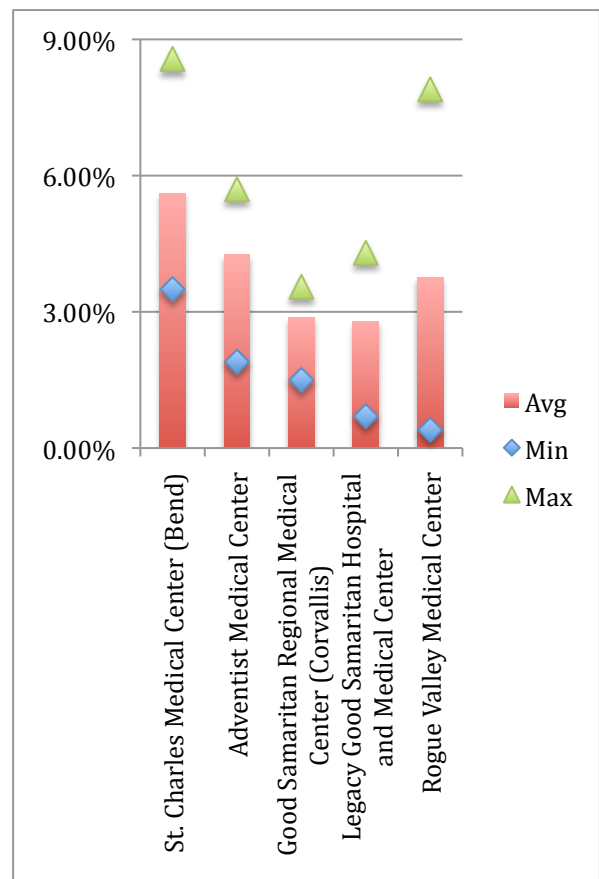
Using a 3 percent operating margin as an indicator of financial health, SCHS is healthy. Figure 1 shows the average operating margin for the Bend facility and SCHS since 2009. Over this period, the Bend hospital earned an average operating margin of 5.5%, and SCHS overall earned an average operating margin of 3.3%. Thus, recent operating margins suggest that SCHS is healthy.

While annual operating margins do fluctuate from year-to-year (particularly given recent economic weakness), SCHS earned solid operating margins over the past several years. Going back to 2005, the Bend facility exceeds the 3 percent benchmark in each year. System-wide,

SCHS fell below 3 percent in some years, but the average over the whole period exceeds the 3 percent benchmark.

Furthermore, the Bend facility's operating margin consistently exceeds that of its peer hospitals in Oregon. Figure 2 shows the average (the red bars), the minimum (the blue diamonds), and the maximum (the green triangles) operating margin for other hospitals in Oregon of similar size to SCHS Bend. The Bend facility saw higher average, maximum, and minimum operating margins during 2005-2009.

**Figure 2. Average, Maximum, and Minimum Operating Margin 2005-2009, SCHS Bend and Peer Hospitals**



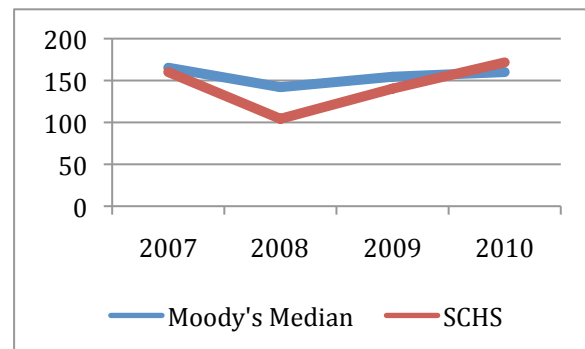
Source: ECONorthwest analysis of audited financial data.

Beyond profitability, hospital analysts worry about hospitals' ability to survive adverse shocks, to pay their debts, and their needs to make large capital investments. Along all of these dimensions, SCHS performs well and its performance has improved in recent years. We briefly describe SCHS's performance on several indicators in this section. Additional details and comparisons are described in the Appendix.

One indicator frequently cited by analysts as an indicator of hospital financial health is the number of days of cash on hand. This measure describes how many days a hospital could continue to operate if it received no revenue. The lower the number the more vulnerable the hospital is to unexpected shocks (e.g., slow reimbursement or sharp increases in costs).

Figure 2 illustrates that after dipping in 2008, SCHS's days of cash on hand has rebounded to greater than 170. This level exceeds the median single state hospital system rated by Moody's Investors Service (160.1) and is approaching the median for hospitals given an A rating (upper medium grade and subject to low credit risk) by Moody's (179.7 days in FY2010).<sup>xi</sup> SCHS also outperforms other hospital systems in Oregon that primarily serve small metro-areas.<sup>xii</sup> E.g., Samaritan Health System (which includes Good Samaritan Regional Medical Center in Corvallis) had 59 days of cash on hand in 2010 and Asante Health System (which operates Rogue Valley Medical Center in Medford) had 51 days of cash on hand.<sup>xiii</sup>

**Figure 3. Days Cash on Hand, SCHS and Median Moody's Single State Hospital System**



Source: ECONorthwest analysis of SCHS data and Moody's (2011)

Another indicator commonly examined by analysts is the debt-to-capitalization ratio (long term debt divided by total capitalization). This ratio describes the fraction of a hospital's assets that are still being paid off. A higher debt-to-capitalization ratio indicates the hospital is more leveraged. Highly leveraged hospitals may not be able to take on additional debt and may have difficulty making scheduled debt services payments.

In FY2010, SCHS reported its debt-to-capitalization ratio improved from 40.2% in FY2009 to 36.1%. This compares favorably to the median hospital given an A rating by Moody's (38.6%).<sup>xiv</sup> SCHS also compares well to other Oregon hospital systems that primarily serve small metro-areas. Both Asante and Samaritan health systems had debt-to-capitalization ratios greater than 45 percent in 2010.<sup>xv</sup>

Another indicator commonly examined by analysts is the average age of plant. This indicator is important because older facilities are more likely to require expensive renovation or replacements.

Thus, this indicator warns of potentially looming cost (and likely debt) increases.

The average age of plant at SCHS is relatively low. In 2010, it was 7.0 years. This is well below the median for single-state hospital systems rated by Moody's (10.3 year) and well below the median for hospitals given an A rating (10.1 years).<sup>xvi</sup> SCHS's average age of plant is also lower than its peer hospital systems in Oregon (Asante >11 years, Samaritan >9 years).<sup>xvii</sup>

To understand the financial health of a hospital or hospital system, it may also be useful to consider the conditions of the truly sick. Some U.S. hospitals really are financially struggling. For instance, a recent analysis of New Jersey hospitals identified 12 financially distressed hospitals – all of whom had negative operating margins for two of more consecutive years, less than 20 days of cash on hand, and debt-to-capitalization ratios greater than 50 percent.<sup>xviii</sup> Similarly, the median hospital or hospital system rated below Baa by Moody's had a negative operating margin, 75 days cash on hand, debt-to-capitalization of 58 percent, and an average age of plant of 13.5 years.<sup>xix</sup>

SCHS's financial indicators are nowhere near these unhealthy levels. It is profitable. It has sufficient liquidity to absorb shocks. It is not over-leveraged. It can pay its current debts. It has relatively new facilities. It is not surprising, then, that Moody's upgraded SCHS's outlook from stable to positive in December 2010 and that Moody's hinted that a ratings upgrade may follow as SCHS continues to pay down its debt.<sup>xx</sup>

While SCHS experienced some weakness during the first few months of 2011 (it

showed a small operating loss at the end of June), data from August indicates that SCHS's performance recovered in recent months (generating sufficient operating income to offset the losses from the first six months and achieve a net income of over \$5 million). Even if overall 2011 performance is weaker than in 2009 or 2010, looking across the past three years, the system appears healthy. Barring some significant structural change, as the economy recovers, SCHS's financial performance will likely improve.

#### **IV. LOOKING FORWARD, WHAT ARE THE HOSPITAL'S PROSPECTS? WILL HEALTH CARE REFORM ADVERSELY AFFECT SCHS?**

*SCHS's financial health is unlikely to decline in the near future. Even after health reform implementation, economists expect spending on health care in the U.S. to continue to rise. Barring substantial declines in Central Oregon's population or economy, SCHS will benefit from the expected growth in health care spending.*

SCHS is the dominant provider in an industry that consistently performs well (even during recessions) in a region with a growing population. For its financial performance to suffer in the future, SCHS would need to experience some combination of the following: significantly lower payments, significantly lower utilization, or significantly higher costs. Given current expectations, it is hard to imagine any of these occurring at a scale sufficient to cause SCHS to become financially troubled in the near future.

As described in section II, SCHS worries about declining prices. SCHS attributes at least some of its “weakness” in 2011 to a decline in the share of patients with commercial insurance. Since government insurers pay less than commercial insurers, a decline in the share of patients with commercial insurance reduces SCHS’s margins.

SCHS views this trend as a harbinger of things to come. SCHS argues that health care reform and other policy changes will reduce the prices paid by government health care providers and increase the share of patients covered by government insurance programs.

However, health care economists expect other factors to offset many if not all of these concerns. First, the health care reform bill is expected to substantially increase the share of the population with insurance from 82 percent to 95 percent.<sup>xxi</sup> This will increase hospital revenues through two channels. First, people with insurance consume more health care, so reform is expected to increase utilization. Second, people with insurance can pay for health care, thus hospitals will provide less charity care and incur fewer bad debts.

The expansion in insurance coverage will not be driven exclusively by increases in the population covered by government insurance programs. Economists expect many of the previously uninsured to obtain commercial insurance. For instance, MIT economist Jonathan Gruber estimates that approximately 440,000 otherwise uninsured Oregonians will obtain health insurance coverage by 2019 and 260,000 of these will obtain commercial insurance.<sup>xxii</sup> As such, health care reform will replace much of SCHS’s

bad debt and charity care with commercially insured patients (as well as some government insured patients). These changes will help SCHS’s bottom line.

Some of these improvements may be offset by lower payments from Medicare and Medicaid; however, several analyses find that, in the aggregate, the expected increase in revenues from greater insurance coverage almost exactly offsets the decline in revenues from lower Medicare and Medicaid payments.<sup>xxiii</sup> For instance, one study estimates that lower payments will reduce spending by \$416 billion during 2010-2019 (assuming that hospitals do not offset lost revenue from government programs by charging commercial insurers more<sup>xxiv</sup>); however, greater insurance coverage will increase health care spending by \$415 billion over the same period.<sup>xxv</sup> While these two effects offset in the aggregate, the hospitals that gain the most from increased insurance coverage may not be the same as those who lose the most from cuts to Medicare and Medicaid.

Second, health care reform may change how health care is delivered and these changes (or modernizations) may affect hospital revenues.<sup>xxvi</sup> The impact of these reforms is highly uncertain, however.<sup>xxvii</sup> Some analysts do not expect the changes to substantially affect health care costs at all. Even those who are more optimistic about reform’s ability to curb costs acknowledge that reform will not reduce costs but, at best, may reduce the rate of cost growth from 6.1 percent per year to 5.7 percent per year.<sup>xxviii xxix</sup>

While some of this slowing may come from slower growth in payments to hospitals, economists expect a substantial

portion of the slowdown in growth to come from reduced insurance and hospital administrative costs. That would mean reduced hospital costs for the public would reflect lower expenses for hospitals, not lower hospital profits.<sup>xxx</sup>

Looking forward, SCHS's prospects are good. Health care spending is expected to continue to grow faster than the economy, and Bend's population is expected to continue to grow (it grew 49.1% between 2000 and 2010, another 0.6% between 2010 and 2011, and Moody's expects it to be one of the 10 strongest housing markets in the nation by 2014<sup>xxxii</sup>). As the region's dominant health care provider, SCHS, will benefit from these trends. As such, we do not expect SCHS to experience substantial declines in its financial health over the next several years.

## **V. HOW WOULD IT AFFECT SCHS'S FINANCIAL PERFORMANCE TO GIVE SEIU-REPRESENTED WORKERS A 3.5% RAISE FOR EACH OF THE NEXT THREE YEARS?**

An annual raise of 3.5 percent for each of the next three years for the 600 workers represented by SEIU would cost approximately \$525,000 in the first year and \$1.6 million by the third year. This amounts to between 0.1 and 0.3 percent of SCHS's 2010 operating revenue or less than the amount paid to between one and four SCHS executives in 2010.

Holding all else constant (i.e., assuming that a wage increase would not affect SCHS's prices, volumes, or employment), a 3.5% in each of the next three years for the workers represented by SEIU would have a modest effect on SCHS's bottom line. It would take significantly greater increased expenditures to jeopardize the system's financial health.

SEIU represents 600 workers who earn less than \$15/hour on average. In 2010, total wages for all 600 were approximately \$15 million. A 3.5% annual increase would cost the employer less than half a million dollars in the first year, a little over \$1 million in the second year; and about \$1.6 million in the third year or about \$1 million per year over the three-year period.<sup>xxxiii</sup>

To help provide some context, \$1 million is far less than SCHS paid its four highest paid executives (over \$1.7 million) or its two highest paid physicians in 2010 (nearly \$2 million).<sup>xxxiii</sup>

Alternatively, in 2010, the Bend facility had operating revenues of approximately \$397 million and SCHS earned revenues of approximately \$479 million. Thus, a \$1.6 million increase in wages for SEIU workers would cost SCHS 0.4 percent of the Bend facility's annual operating revenue and 0.3 percent of SCHS's overall operating revenue. In 2010, the Bend facility had operating margins (or profits) of approximately \$21 million and SCHS had operating margins of approximately \$14.5 million. Thus, a \$1.6 million increase in wages for SEIU workers amounts to 7.6 percent of the operating profit from the Bend facility or 11 percent of the operating profit for SCHS overall.

Holding everything else constant, an annual 3.5 percent wage increase for the SEIU workers would increase costs and reduce SCHS's operating margins; however, not everything else will remain constant indefinitely. The hospital could choose to offset wages increases for SEIU workers by cutting other expenses or raising prices (if the market allows it).

Thus, we cannot say for certain how a wage increase would impact SCHS's operating margins; however, regardless of how or whether a wage increase in wages might be offset, an average increase in annual expenses equal to \$1 million would have limited impact on SCHS's financial health.

## APPENDIX

This appendix includes additional financial indicators for SCHS over the past several years as well as indicators for a variety of comparison hospital systems for 2010.

**Table 1. St. Charles Performance Indicators**

	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>
Operating Margin	0.3%	-0.1%	5.2%	3.0%
EBIDA Margin	7.5%	7.3%	14.4%	12.1%
Days Cash on Hand	160	104	140	172
Current Ratio	N/A	1.5	1.72	1.83
Debt Service Coverage	4.8	-0.2	4.4	3.3
Age of plant	7.2	7.7	7.2	7.0
Discharges	15,860	17,598	17,607	17,558
Total Operating Revenue (Thousands)	\$368,132	\$426,951	\$476,673	\$478,867

**Table 2. St. Charles Health System Financial Indicators Comparison**

	SCHS 2010	Benchmark	Moody's Median A	Moody's Median B	Samaritan (includes Corvallis) 2010	Asante (includes Medford) 2010
Operating Margin	3.0%	3.0% <sup>1</sup>	2.6%	-4.7%	1.3%	6.8%
EBIDA Margin	12.1%	4-8% <sup>2</sup>	N/A	N/A	5.9%	15%
Days Cash on Hand	172	60 <sup>3</sup>	180	38	59	51
Current Ratio	1.8	2.0 <sup>4</sup>	1.9	1.2	2.6	1.7
Debt Service Coverage	3.3	3 <sup>5</sup>	4.8	0.4	N/A	0.76
Discharges	17,558	N/A	22,765 <sup>6</sup>	18,278	18,392	23,644
Total Operating Revenue (Thousands)	\$478,867	N/A	\$509,564	\$317,968	\$699,599	\$496,719

<sup>1</sup> Oregon Office of Health Policy and Research (2011) "Oregon's Acute Care Hospitals: Capacity, Utilization, and Financial Trends 2007 to 2009." Harrison and Montalvo (2002), Ingenix Consulting (2010)

<sup>2</sup> Pillari, G. and G. Sansome (2008) "Hospital Insolvency: The Looming Crisis." Alvarez and Marshal, March 2008.

<sup>3</sup> Pink, George H. et al. "Developing Financial Benchmarks for Critical Access Hospitals." *Health Care Financing Review*. Spring 2009.

<sup>4</sup> Ibid, New Jersey Commission on Rationalizing Health Care (2008) *New Jersey Commission on Rationalizing Health Care: Final Report, 2008*.

<sup>5</sup> Pink et al (2009)

<sup>6</sup> Moody's reports admissions and not discharges.

## End Notes

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- <sup>i</sup> Cliff, B.Q. (2011) “St. Charles Operating in the Red; 3 Jobs Cut” *Bend Bulletin* August 3, 2011
- <sup>ii</sup> St. Charles Health System (2011) Financial Update for SEIU September 27, 2011.
- <sup>iii</sup> See Footnote 2.
- <sup>iv</sup> SEIU negotiator.
- <sup>v</sup> St. Charles Health System, Inc. Annual Disclosure Report FY2010.
- <sup>vi</sup> Pink, G.H., G.M. Holmes, C. D’Alpe, L.A. Strunk. (2006) “Financial Indicators for Critical Access Hospitals.” *Journal of Rural Health* 22(3):229-236.
- <sup>vii</sup> Harrison, M.G. and C.C. Montalvo (2002) “The Financial Health of California Hospitals: A Looming Crisis.” *Health Affairs* 21(1): 118-126.
- <sup>viii</sup> Oregon Office of Health Policy and Research (2011) “Oregon’s Acute Care Hospitals: Capacity, Utilization, and Financial Trends 2007 to 2009.”
- <sup>ix</sup> Moody’s Investors Service (2011) “U.S. Not-for-profit hospital medians show resiliency against industry headwinds but challenges still support negative outlook.” August 30, 2011.
- <sup>x</sup> Ingenix Consulting (2010) “Five Imperatives for Healthy Hospitals Under Health Care Reform.”
- <sup>xi</sup> Moody’s (2011)
- <sup>xii</sup> While we included Adventist and Legacy Good Samaritan in the comparison of hospital facilities described in Figure 2, we do not include their parent systems in our analysis of other metrics. The other metrics we examine in this report describe system level characteristics and these hospitals are part of hospital systems that are much larger and serve a very different area than small metro-area systems like SCHS, SCS, and Asante.
- <sup>xiii</sup> ECONorthwest analysis of data from hospital system financial statements.
- <sup>xiv</sup> Moody’s (2011)
- <sup>xv</sup> ECONorthwest analysis of consolidated financial statements.
- <sup>xvi</sup> Moody’s (2011)
- <sup>xvii</sup> ECONorthwest analysis of consolidated financial reports.
- <sup>xviii</sup> New Jersey Commission on Rationalizing Health Care (2008) *New Jersey Commission on Rationalizing Health Care: Final Report, 2008*.
- <sup>xix</sup> Moody’s (2011)
- <sup>xx</sup> [http://www.bondsonline.com/Todays\\_Market/Credit\\_Rating\\_News\\_.php?DA=view&RID=6833](http://www.bondsonline.com/Todays_Market/Credit_Rating_News_.php?DA=view&RID=6833)
- <sup>xxi</sup> The Congressional Budget Office.
- <sup>xxii</sup> Kolmer, S. “Estimates of Coverage Expansions from Federal Reform” <http://www.oregon.gov/OHA/OHPR/LEG/docs/Gruber.pdf>
- <sup>xxiii</sup> E.g., Cutler, D., K. Davis, and K. Stremkis (2010) “The Impact of Health Reform on Health System Spending.” The Commonwealth Fund Issue Brief, May 2010.; Berenson, R. and S. Zuckerman (2010) “How Will Hospitals be Affected by Health Care Reform?” Robert Wood Johnson Foundation and The Urban Institute, July 2010.
- <sup>xxiv</sup> It is possible that some hospitals may be able to offset lost revenue from government providers by charging commercial providers more. This process (known as cost shifting) may or may not occur. Frakt, A. (2011) reviews the literature on cost shift and finds that it may occur, but only to a limited extent. Frakt, A. (2011). “How much do hospitals cost shift? A review of the evidence.” *Milbank Quarterly* 89(1)

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- xxv Cutler et al (2010)
- xxvi Sweeney, L. (2010) “Health Care Reform Could Increase Credit Risk for U.S. Not-For Profit Providers.” Standard & Poor’s Global Credit Portal Ratings Direct, May 13, 2010.
- xxvii Cutler et al (2010), Sweeney (2010)
- xxviii Cutler et al (2010)
- xxix Cutler et al (2010)
- xxx Ibid.
- xxxi Portland State Population Center <http://pdx.edu/prc/>; Moody’s (<http://realestate.msn.com/slideshow.aspx?cp-documentid=25109508>)
- xxxii ECONorthwest analysis of data provided by SCHS.
- xxxiii ECONorthwest analysis of SCHS Form990 for 2010.