

POLICY BRIEF

# A PREVENTABLE CRISIS

The Unnecessary Cuts to Medicare, Medicaid, and ACA Threatening 602 Hospitals and the Communities They Serve



July 2026

**RED ALERT**

**National Nurses United**

[www.NationalNursesUnited.org](http://www.NationalNursesUnited.org)



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## INTRODUCTION

The U.S. hospital industry currently faces a coordinated fiscal contraction driven by three distinct federal revenue cuts:

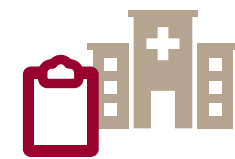
1. A mandatory two percent **Medicare** sequestration triggered by federal debt levels.
2. A projected 10 to 18 percent reduction in **Medicaid** funding under H.R. 1.
3. The expiration of enhanced **Affordable Care Act (ACA)** marketplace subsidies.

This study applies the combination of these three federal revenue cuts to a cohort of **602 financially vulnerable hospitals** that are already operating from an aggregate \$10.16 billion deficit. It assesses the financial impact of the coordinated fiscal contraction and its distribution by geography and patient population.

Altogether, this study estimates an additional **50 to 75 percent in aggregate deficit** across the 602 financially vulnerable hospitals because of this coordinated fiscal contraction.

Enacted on July 4, 2025, as part of H.R. 1, the cuts to Medicaid and ACA subsidies are the primary driver of this fiscal shock that threatens to deteriorate vulnerable hospitals' finances. According to the Congressional Budget Office, H.R. 1's tax provisions deliver the largest benefits to the wealthiest households in America. To do so, it puts the nation's most fragile health care providers, who serve some of the nation's most vulnerable communities, at risk of cuts and closures. *Appendix D: CBO Distributional Analysis of Public Law 119-21* provides further information.

The cost of these federal policy changes is not measured in industrial profits. Instead, the cost is measured in delayed emergency care, forgone preventive services, increased financial burden on families and employers, and diminished local economies, including job losses in areas where hospitals are often the largest employers. Ultimately, it is communities, not the hospital industry, who pay the price for and bear the brunt of these fiscal cuts, whether through the complete closure of a facility, conversion to outpatient or free-standing emergency care, the elimination of specialized services like oncology and maternity care, the reduction of charity care, or increased prices for remaining patients. This study offers immediate and long-term policy solutions to offset the expected consequences of communities losing access to life-saving care.



**3,911**

Hospitals Analyzed



**50-75%**

Increase in Hospital Deficit Following Health Care Cuts



# The Financially Vulnerable Hospitals

This study analyzes the financial condition of 602 financially vulnerable hospitals. Collectively, **the 602 financially vulnerable hospitals carry an aggregate net income deficit of \$10.16 billion**, all accumulated before a single dollar of the three federal revenue cuts takes effect. This is not a projection or a worst-case scenario. This is the current financial reality of these institutions, documented in their most recent Medicare Cost Report filings.

These 602 hospitals were identified from a dataset of 3,911 hospitals, using Medicare Cost Report data through December 31, 2025, and scored using the Financial Vulnerability Index, developed by National Nurses United (NNU) for this analysis.

## The Financial Vulnerability Index

To identify hospitals at greatest risk from the three concurrent fiscal shocks, NNU developed a Financial Vulnerability Index based on each hospital's five-year financial history. The index is a composite measure weighted toward net income performance, as operating income is the primary indicator of a hospital's ability to absorb revenue reductions.

The Index ranges from -10 (most vulnerable) to 0 (no vulnerability flags). A hospital scoring in the range -7 to -10 on this index has demonstrated simultaneous, sustained failure across multiple financial dimensions over a period of time including: persistent net losses, recent annual deficits, and deteriorating or negative net worth.

Out of 3,911 hospitals analyzed, 602 hospitals scored between -7 to -10, indicating severe fiscal distress before any of the three federal revenue cuts take effect.

The complete list of the 602 financially vulnerable hospitals is provided in *Appendix E*.

The scoring methodology, component weights, and financially vulnerable threshold are detailed in *Appendix A: Financial Vulnerability Index Methodology*.

TABLE 1

Variable	Condition	Score
<b>Net Income</b>	<b>Range -6 to 0</b>	
Total Net Income (5-year sum)	Negative over 5 years	-3
Annual Net Income — Year 1 (most recent)	Negative	-1
Annual Net Income — Year 2	Negative	-1
Annual Net Income — Year 3	Negative	-1
<b>Net Income</b>	<b>Range -4 to 0</b>	
Net Worth (latest year)	Negative	-2
Net Worth trend (5-year)	Deteriorating	-2
<b>Total Financial Vulnerability Index</b>		<b>-10 to 0</b>

Note: Variables not meeting the above conditions receive a score of zero. The maximum possible score is 0 (no vulnerability flags); the minimum is -10 (all conditions present).



# Triple Threat of Fiscal Contraction

## 1. Medicare:

Sequestration and Reimbursement Pressure



Federal law requires automatic spending reductions, known as sequestration, when projected deficits exceed statutory thresholds. Under current law, Medicare payments to providers are subject to a mandatory two percent sequestration cut. This reduction applies directly to Medicare reimbursement rates, compressing margins for hospitals that depend heavily on Medicare as their primary payer.<sup>1</sup>

Furthermore, because H.R. 1 is projected to increase the federal deficit, the Congressional Budget Office (CBO) estimates it would trigger approximately \$500 billion in mandatory Medicare cuts between 2026 and 2034, including a four percent cut to hospital payments, unless Congress enacts offsetting legislation.<sup>2</sup> The four percent reduction is not included in this analysis, as Congress enacted legislation to override the Pay-As-You-Go (PAYGO) requirement and historically Congress has never allowed PAYGO cuts to occur.<sup>3</sup> However, there is no guarantee of the cancellation in the future.

## 2. Medicaid:

Funding Reductions Under H.R. 1



H.R. 1, signed into law on July 4, 2025, introduces sweeping changes to the Medicaid program with direct consequences for hospital finances. The legislation creates new work requirements and eligibility conditions for Medicaid enrollees, restricts states' ability to use provider taxes to finance their share of Medicaid costs, and caps state-directed payments. Each of these changes disproportionately affects safety-net hospitals serving low-income populations.<sup>4</sup>

The distributional consequences of H.R. 1 are stark. The CBO's analysis found that the legislation's tax provisions deliver the largest financial benefits to the highest-income households, while reducing 10 to 18 percent<sup>5,6</sup> of Medicaid funding for community hospitals that treat a higher proportion of patients who depend on Medicaid and ACA coverage. In other words, through higher medical bills and lower health outcomes, low-income Americans will bear the cost of H.R. 1's tax benefits for the wealthiest Americans.<sup>7</sup>

H.R. 1 includes a \$50 billion Rural Health Transformation Program (RHTP), cited by some as offsetting the Medicaid cuts. In reality, it makes available funding that could offset an estimated 37 percent of rural Medicaid losses if, and



only if,<sup>8</sup> states apply for and receive those funds. Critically, RHTP funds are restricted to transformation activities and cannot be used to replace lost Medicaid revenue or cover operating losses.<sup>9</sup> The program entirely excludes the 366 financially vulnerable hospitals in metropolitan areas, 61 percent of this study's cohort. Moreover, the program does not come close to covering the \$5.19 to \$7.67 billion in projected stress losses across the full cohort. As *The New York Times* reports, the biggest impacts of the Medicaid cuts may not be in rural areas, but in cities where the RHTP provides no relief.<sup>10</sup>

### 3. ACA Marketplace Subsidies:

#### Expiration and Coverage Loss



The enhanced premium tax credits that expanded ACA marketplace enrollment expired at the end of 2025. The consequences for both coverage and hospital revenue have been immediate and significant.

Average marketplace premiums have more than doubled for many enrollees, resulting in significant coverage losses. Centers for Medicare and Medicaid Services (CMS) data show that ACA marketplace sign-ups dropped by approximately 1.2 to 1.3 million consumers during the 2026 Open Enrollment Period when compared to the same point in 2025. This is the actual enrollment data, not a projection.<sup>11</sup> The Urban Institute projects that, as the full effect of the subsidy expiration plays out, 4.8 million more people will be uninsured in 2026 than would be under a policy that extends enhanced subsidies, resulting in a 21 percent increase in the uninsured population.<sup>12</sup>

For hospitals, the coverage losses translate directly into lost revenue and increased uncompensated care. Providers face an estimated \$14.2 billion in lost hospital revenue in 2026, alongside a \$2.2 billion increase in uncompensated care demand. These costs fall disproportionately on hospitals already operating at or near financial distress. These figures represent hospital-specific impacts, within a total estimated \$32.1 billion in lost provider revenue across all health care sectors in 2026.<sup>13</sup>



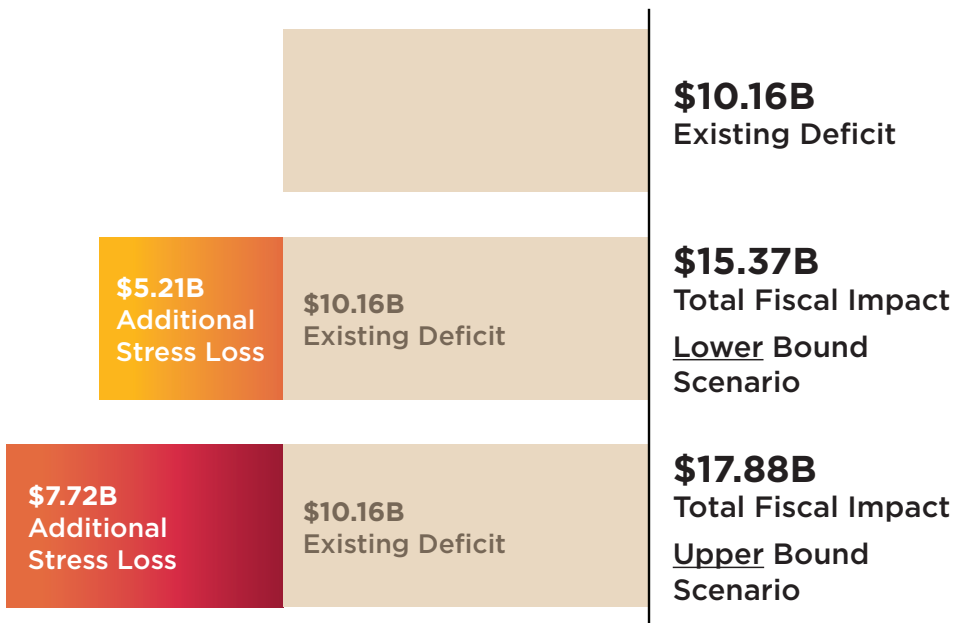
# The Impact of the Triple Threat

Applying each revenue reduction to the 602 financially vulnerable hospitals, NNU estimates their **aggregate losses would increase by between 50 and 75 percent**. In other words, the combined fiscal contraction would add between \$5.21 billion and \$7.72 billion to a deficit that already exceeds \$10 billion.

In total, projected losses range from \$15.37 billion to \$17.88 billion across these 602 hospitals — a figure that includes the \$10.16 billion deficit they were already carrying before the cuts took effect.

FIGURE 1

## Projected Aggregate Deficit of 602 Financially Vulnerable Hospitals



*Note: The lower bound scenario reflects the financial impact of the three shocks with a 10 percent reduction in Medicaid funding, while the upper bound scenario reflects the financial impact of the three shocks with an 18 percent reduction in Medicaid funding.*

## Distribution of Stress Losses Across the 602 Hospitals

The stress losses are not uniformly distributed across the 602 financially vulnerable hospitals. The wide gap between mean and median values reflects a highly skewed distribution. A relatively small number of larger hospitals account for a disproportionate share of the total projected losses, while the majority of affected facilities are smaller community and rural hospitals facing relatively smaller, but no less consequential, revenue reductions.

The median loss of \$3.4 million to \$4.7 million per hospital is particularly alarming. For a community hospital already running a deficit, a revenue reduction of this magnitude is not an operational challenge, but a potential trigger for facility closure. The maximum single hospital stress loss of \$180 million to \$316 million reflects the extreme exposure faced by larger safety-net facilities serving dense, low-income populations with heavy Medicaid and marketplace payer mixes.

TABLE 2

Statistic <i>Hospitals (N)</i>	Lower Bound <i>(602)</i>	Upper Bound <i>(602)</i>
Mean Loss per Hospital	\$8,656,654	\$12,824,031
Median Loss per Hospital	\$3,352,878	\$4,722,754
Minimum Loss	\$123,217	\$125,995
Maximum Loss	\$180,781,758	\$316,373,451
<b>Total Aggregate Stress Loss</b>	<b>\$5,211,305,572</b>	<b>\$7,720,066,507</b>

The cuts do not just worsen the condition of the most distressed; they also reverse the progress of those beginning to recover. Of the 602 financially vulnerable hospitals, 96, or nearly 1 in 6, had achieved positive net income in their most recent reporting year, suggesting that financial recovery was underway for a meaningful share of the cohort. The three revenue cuts would devastate that progress: under the lower bound scenario, the number of hospitals with positive net income falls from 96 to just 37 (6.1 percent); under the upper bound, it falls to 23 (3.8 percent). In other words, between 59 and 73 hospitals that were beginning to stabilize would be pushed back into financial deficits.

TABLE 3

Net Income Status <i>Hospitals (N)</i>	Before Cuts <i>(602)</i>		Lower Bound <i>(602)</i>		Upper Bound <i>(602)</i>	
Hospitals with Positive Net Income	96	15.9%	37	6.1%	23	3.8%
Hospitals with Negative Net Income	506	84.1%	565	94.0%	579	96.2%
<b>Hospitals Losing Positive Net Income</b>			<b>59</b>		<b>73</b>	

# Geographic Distribution: A National Crisis, Not a Regional One

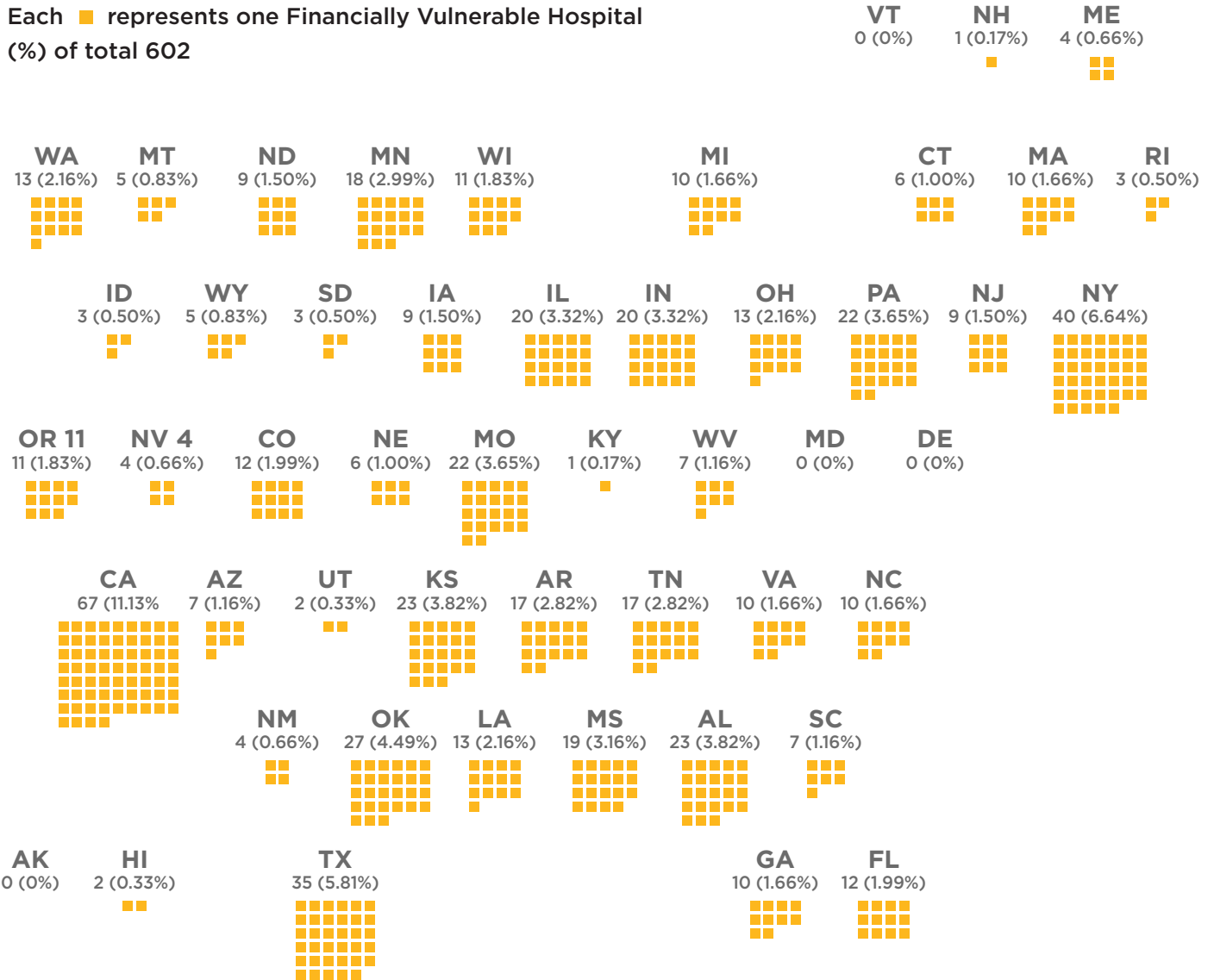
The 602 financially vulnerable hospitals are distributed across 47 states, representing every region of the country and leaving few congressional districts unaffected.

Figure 2 presents the distribution of the 602 financially vulnerable hospitals by state. The five states with the largest concentrations are California (67), New York (40), Texas (35), Oklahoma (27), Kansas (23), and Alabama (23). Notably, Oklahoma and Kansas rank among the top five despite their relatively modest populations, which is a reflection of the high density of rural and Critical Access Hospital facilities in these states and their historically thin hospital margins.

FIGURE 2

## Financially Vulnerable Hospitals by State

Each ■ represents one Financially Vulnerable Hospital  
(%) of total 602



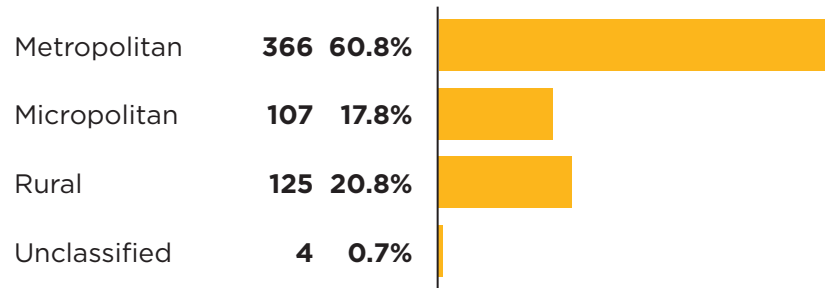
Financial vulnerability at this level is not a product of local mismanagement or regional economic decline. Rather, it is a structural consequence of how hospitals serving high proportions of government-insured and uninsured patients are funded nationally.

A common assumption is that hospital financial distress is primarily a rural phenomenon. The data challenges that framing. Nearly 61 percent of the financially vulnerable

hospitals, or 366 facilities, are located in metropolitan areas,<sup>15</sup> where they function as safety-net providers for urban low-income populations. The 20.8 percent in rural areas and 17.8 percent in micropolitan communities represent a distinct but equally urgent crisis. In these markets, the financially vulnerable hospital is frequently the only hospital, and its closure leaves entire communities without access to acute care.

FIGURE 3

### Financially Vulnerable Hospitals, by Community Type



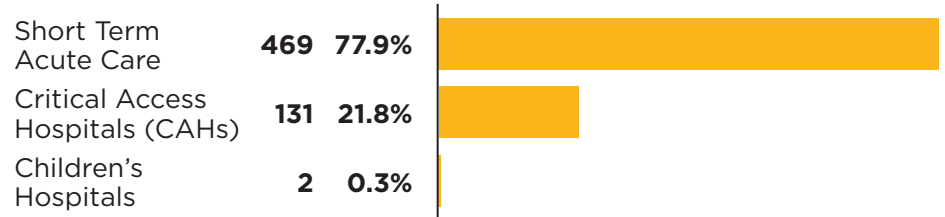
Source: Community type classifications derived from the AHA Annual Survey Database, 2024.<sup>14</sup>

## Hospital Type: The Backbone of Community Care at Risk

The 131 Critical Access Hospitals (CAH) in the financially vulnerable cohort warrant particular attention. CAHs are, by federal designation, the sole or primary hospital serving rural communities. Closure would mean the elimination of emergency, surgical, and inpatient care for entire counties. The 469 Short Term Acute Care hospitals represent the workhorse institutions of urban and suburban health care. These are community hospitals that handle most inpatient admissions, emergency visits, and surgical procedures for working-class and low-income populations.

FIGURE 4

### Financially Vulnerable Hospitals, by Community Type



## The Cost of Inaction

The 602 financially vulnerable hospitals identified in this study are integral pieces of health care infrastructure in communities across 47 states. They are the largest employer in many of the counties they serve. They are often the closest or only source of emergency care for millions of Americans. They provide charity care, behavioral health services, obstetric care, and chronic disease management that few other institutions in their communities are positioned to provide.

Without urgent action, the data show the financial outlook for these hospitals is dire. Just as importantly, so is the future of patient care and public health in the communities they serve, measured in higher mortality rates, in poorer health outcomes, in economic decline, and in the permanent erosion of community resilience.

Investments in the health of U.S. communities must be made now, before further deterioration narrows or eliminates the available options and increases the cost of intervention.

# A Clear and Urgent Policy Imperative

The findings of this study point to a clear and urgent policy imperative.

The central question for policymakers is not whether to act. It is whether to act now, at lower cost and with greater effectiveness to maintain essential services that sustain human health and local economies, or to act later in response to closures, service eliminations, and community health crises that will be far more expensive and far harder to reverse.

## RECOMMENDATION 1

### Cancel the Three Federal Revenue Cuts

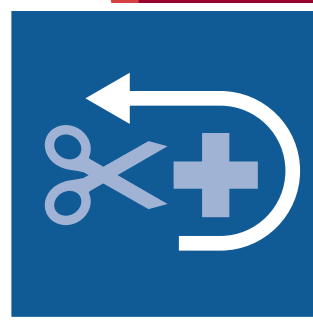
The most direct and immediately effective policy response is the cancellation or reversal of all three federal revenue cuts: the two percent Medicare sequestration, the Medicaid funding reductions under H.R. 1, and the expiration of enhanced ACA marketplace subsidies. While these three cuts did not create the underlying financial vulnerability of the 602 hospitals, they will dramatically accelerate it. Applied simultaneously to hospitals already running a combined \$10.16 billion deficit, they represent a fiscal shock that will push the most distressed institutions toward a point where recovery becomes increasingly difficult.

Cancellation would remove the immediate accelerant and preserve the time and capacity needed to address the underlying problems through the longer-term structural intervention described in Recommendation 2.

## RECOMMENDATION 2

### Establish the Financial Vulnerability Program (FVP)

Regardless of the outcome of Recommendation 1, Congress should establish a Financial Vulnerability Program (FVP) at hospitals serving communities where current reimbursement



structures are structurally insufficient to sustain essential health care access. The FVP would act as a cost-based reimbursement mechanism modeled on the existing Critical Access Hospital (CAH) program. Targeted hospitals that have closed have been disproportionately concentrated in the -7 to -10 range of the Financial Vulnerability Index, making early intervention through the FVP substantially less costly than the community health and economic consequences of closure.

The FVP would reimburse qualifying hospitals at 101 percent of reasonable costs for Medicare and Medicaid, providing the margin necessary to sustain operations without generating profit. Designed as a community access program, not a hospital profitability program, the FVP's purpose would be to ensure that populations served by financially distressed hospitals in urban and rural communities retain access to essential care regardless of payer mix. Participation is not permanent, as hospitals would move into and out of the program as their Financial Vulnerability Index scores change annually.

## FVP Eligibility: A Tiered Approach Based on the Financial Vulnerability Index

FVP eligibility would be determined by a hospital's score on the Financial Vulnerability Index, creating a tiered intervention framework that enables early action before financial distress becomes significantly harder to reverse.

TABLE 4

FVI Score	-0 to -4	-5 to -6	-7 to -10
Tier	Financially Stable	Early Warning	Critically Vulnerable
FVP Status	Not eligible	FVP Eligible	FVP Critical Tier
Intervention	No intervention required	101% cost-based reimbursement, financial improvement plan required	101% cost-based reimbursement, enhanced oversight, stricter conditions

## FVP Program Stipulations and Conditions

FVP participation would be conditioned on requirements designed to ensure program resources are directed toward community access preservation, rather than to institutional or financial interests. Community access conditions require participating hospitals to maintain essential service lines, meet charity care minimums, engage community advisory boards, and obtain CMS approval before eliminating any service. Financial accountability conditions require annual Financial Vulnerability Index reporting, CMS-approved improvement plans with defined milestones, executive compensation limits, and restrictions on asset transfers to parent entities for the duration of program participation.



### RECOMMENDATION 3

## Annual Financial Vulnerability Monitoring

CMS should be directed to update the Financial Vulnerability Index annually using Medicare Cost Report data, publishing a transparent list of hospitals in the Early Warning and Critical tiers. This early warning infrastructure serves two purposes. First, it enables proactive FVP enrollment before hospitals reach crisis. Second, it provides Congress and state legislatures with an ongoing, evidence-based tool for assessing the health of the hospital safety net before policy changes are enacted. Had such a monitoring system been in place, the severity of the fiscal shock documented in this study would have already been visible before legislators chose to create it.

## APPENDIX A

# Financial Vulnerability Index Methodology

This appendix details the construction and scoring of the Financial Vulnerability Index used to identify the 602 financially vulnerable hospitals analyzed in this study.

### Financial Vulnerability Index Scoring

The Index is built on net income and net worth in dollar terms rather than margin-based ratios. Margins are useful for comparing performance across hospitals of different sizes, but they obscure magnitude, and magnitude matters. A small rural Critical Access Hospital and a large urban system can share the same margin while one is losing \$500,000 a year and the other \$200 million. Measuring net income and net worth in absolute terms captures the actual scale of financial distress, making it a more meaningful indicator of a hospital's ability to withstand revenue reductions.

The Index comprises four components across two dimensions.

The use of multiple financial variables rather than a single ratio is consistent with prior research on hospital financial distress. Puro et al. (2019) found that no single financial ratio consistently distinguished bankrupt hospitals from financially healthy ones, supporting the multi-dimensional, longitudinal approach used here.<sup>16</sup>

### Financially Vulnerable Threshold

Hospitals scoring in the range -7 to -10 on the Financial Vulnerability Index are classified as financially vulnerable hospitals. A score at this level requires simultaneous failure across nearly all financial dimensions (sustained losses over five years, recent annual losses, and deteriorating or negative net worth), indicating a hospital already in severe fiscal distress before any additional revenue reductions are applied. Of the 3,911 hospitals analyzed, 602 met this threshold, carrying a combined existing deficit of \$10.16 billion.

TABLE 5

Variable	Condition	Score
<b>Net Income</b>		
<i>Range -6 to 0</i>		
Total Net Income (5-year sum)	Negative over 5 years	-3
Annual Net Income — Year 1 (most recent)	Negative	-1
Annual Net Income — Year 2	Negative	-1
Annual Net Income — Year 3	Negative	-1
<b>Net Income</b>		
<i>Range -4 to 0</i>		
Net Worth (latest year)	Negative	-2
Net Worth trend (5-year)	Deteriorating	-2
<b>Total Financial Vulnerability Index</b>		<b>-10 to 0</b>

*Note: Variables not meeting the above conditions receive a score of zero. The maximum possible score is 0 (no vulnerability flags); the minimum is -10 (all conditions present).*

## APPENDIX B

# Methodology

### Data Sources and Sample

This analysis draws on Medicare Cost Reports filed with the Centers for Medicare & Medicaid Services (CMS), representing the primary source of standardized financial data for hospital facilities across the United States. Medicare Cost Reports are self-reported filings submitted to CMS and are subject to CMS review; while not independently audited, they provide consistent, comparable financial statements including net income, net worth, payer mix, and operating data across 3,911 hospitals. The most recent available 2024/2025 reporting periods were used.

To be included in the analysis, a hospital must have completed five consecutive years of net income and net worth data in the Medicare Cost Report database. Hospitals with gaps in their five-year financial history were excluded, as the longitudinal components of the Financial Vulnerability Index cannot be scored without a complete data series. This requirement ensures the integrity of the index scores but means that newly established hospitals, recently converted facilities, and those with reporting gaps are not included in the 3,911-hospital analytical universe.

### Addressing the Managed Care Gap in National Data

A critical challenge in any hospital financial analysis based on Medicare Cost Reports is the systematic undercounting of managed care revenue. Medicare Cost Reports do not report net patient revenue separately by payer in a way that distinguishes managed care from fee-for-service. Medicare Advantage (MA) is not separately identified from traditional Medicare, and Medicaid Managed Care Organization (MCO) payments are not separately identified from fee-for-service Medicaid. As a result, standard analyses based on cost reports alone materially understate hospitals' true dependence on government-funded managed care reimbursement. This limitation is well recognized. Research has documented discrepancies between the Healthcare Provider Cost Reporting Information System and other data sources in the reporting of Medicaid managed care discharges, suggesting that managed care activity may be systematically undercaptured in cost report data.<sup>17</sup> While that research focuses

on discharge volumes rather than revenue, the pattern is consistent with the revenue discrepancies directly observable when comparing Medicare Cost Report data with state-level audited sources such as the California HCAI Hospital Financial Data, which reports net patient revenue by payer with the granularity that cost reports lack. On the MA side, CMS cost reports have traditionally been based on fee-for-service rates and did not separately capture MA negotiated payments, a gap CMS is only now beginning to address with the introduction of a new reporting requirement (Worksheet S-12) for cost reporting periods ending on or after January 1, 2026.<sup>18</sup> The entire historical dataset underlying this study predates that requirement. For financially vulnerable hospitals, this undercount directly understates their exposure to the three fiscal shocks modeled in this study.

### California and Minnesota as Statistical Proxies

To correct for this undercount, this study developed a managed care scaling methodology using audited state-level data from California (HCAI Hospital Audited Financials) and Minnesota (MDH Hospital Annual Reports). These states were selected for three reasons:

- » Enhanced transparency: Unlike most states, California and Minnesota mandate granular reporting of managed care revenue including Medicare Advantage, Medicaid MCO payments, State-Directed Payments (SDPs), and supplemental taxes. This provides a clearer picture of government payer exposure.
- » High managed care penetration: Both states have mature, high-enrollment managed care markets, making them useful proxies for how cuts will impact hospitals nationally as managed care continues to expand.
- » Data harmonization: The difference between these audited state reports and raw Medicare Cost Report data for the same hospitals provides a measurable and reproducible correction factor.

Approximately 400 hospitals from California and Minnesota with complete data in both sources were used to calculate the correction. For each hospital, the difference between the state-reported managed care revenue and the Definitive Healthcare payer mix figure was computed separately for Medicare managed care and Medicaid managed care. The median of these differences — rather than the mean, to guard against distortion by outliers — was then

calculated within two hospital-type segments: Critical Access Hospitals (CAH), which exhibited a materially larger managed care gap, and General Acute Care and Children’s hospitals combined. This produced four correction factors in total:

- » CAH — Medicare Managed Care correction
- » CAH — Medicaid Managed Care correction
- » General Acute / Children’s — Medicare Managed Care correction
- » General Acute / Children’s — Medicaid Managed Care correction

These correction factors were then applied to the Definitive Healthcare payer mix data for all hospitals in the national dataset excluding California and Minnesota, which retained their more granular audited state-reported figures without adjustment. The result is adjusted Medicare and Medicaid revenue estimates intended to better reflect each hospital’s government payer exposure than unadjusted cost report data alone.

It should be noted that California and Minnesota, as high managed care penetration states with above-average reporting requirements, may not perfectly reflect managed care exposure in every state. In lower-penetration states, the correction factor may modestly overstate true exposure; in higher-penetration states, it may modestly understate it. However, any imprecision in this adjustment represents a material improvement over the uncorrected Medicare Cost Report data, which is documented to systematically undercount government-funded managed care revenue. The adjusted figures are a more accurate representation of hospitals’ federal and state reimbursement dependence than the raw federal data alone.

### **Sample: From 667 to 602 Hospitals**

The Financial Vulnerability Index initially identified 667 hospitals scoring in the range –7 to –10 across the 3,911 facilities in the Medicare Cost Report dataset. Of these, 65 could not be matched to Definitive Healthcare payer mix records and were excluded from the stress test to ensure only hospitals with complete, verified payer data were included in the revenue reduction modeling. The final analytical sample is 602 financially vulnerable hospitals with full financial and payer mix data as of December 31, 2025.

## **Fiscal Shock Modeling: Stress Test Methodology**

Revenue reductions were applied to each hospital’s financials based on its adjusted payer-specific revenue rather than flat percentage cuts. This approach more accurately reflects the real-world impact on individual facilities, such a rural Critical Access Hospital with 70 percent Medicare and Medicaid revenue facing fundamentally different exposure than an urban academic medical center with a diversified payer base.

The stress test applies each revenue reduction directly to net income using the most recent annual financial data from Medicare Cost Reports dated December 31, 2025. This approach captures the estimated marginal impact: the point at which a hospital may no longer be able to cover its operating costs. The model does not assume any operational response such as cost reductions or service eliminations; it represents the near-term fiscal shock before any institutional adjustments, making it an appropriate worst-case scenario for policy intervention purposes.

The three shocks were applied as follows:

- » Medicare sequestration: A 2 percent reduction applied to each hospital’s adjusted Medicare revenue (fee-for-service and Medicare Advantage combined after managed care scaling)
- » Medicaid funding reduction: A 10 percent reduction (lower bound) and 18 percent reduction (upper bound) applied to each hospital’s adjusted Medicaid revenue (fee-for-service and Medicaid MCO combined after managed care scaling), reflecting the projected range of H.R. 1 impact.<sup>19, 20</sup>
- » ACA subsidy expiration: State-level percentage reductions in hospital spending on the nonelderly, as published in the Urban Institute’s state-by-state analysis,<sup>21</sup> applied to each hospital’s nonelderly net patient revenue based on its state of operation

The cumulative impact of all three shocks was then summed for each hospital to produce lower bound and upper bound stress loss estimates, which were subsequently layered onto each hospital’s existing net income position to derive total projected losses.

## APPENDIX C

# ACA State-Level Revenue Reduction Data

The following map presents the state-level percentage reductions in hospital spending on the nonelderly derived from Blavin & Simpson (2025).<sup>22</sup> These figures were applied to each hospital's nonelderly net patient revenue based on its state of operation. States showing zero reduction had sufficient alternative coverage mechanisms (primarily Medicaid expansion) to offset the subsidy loss.

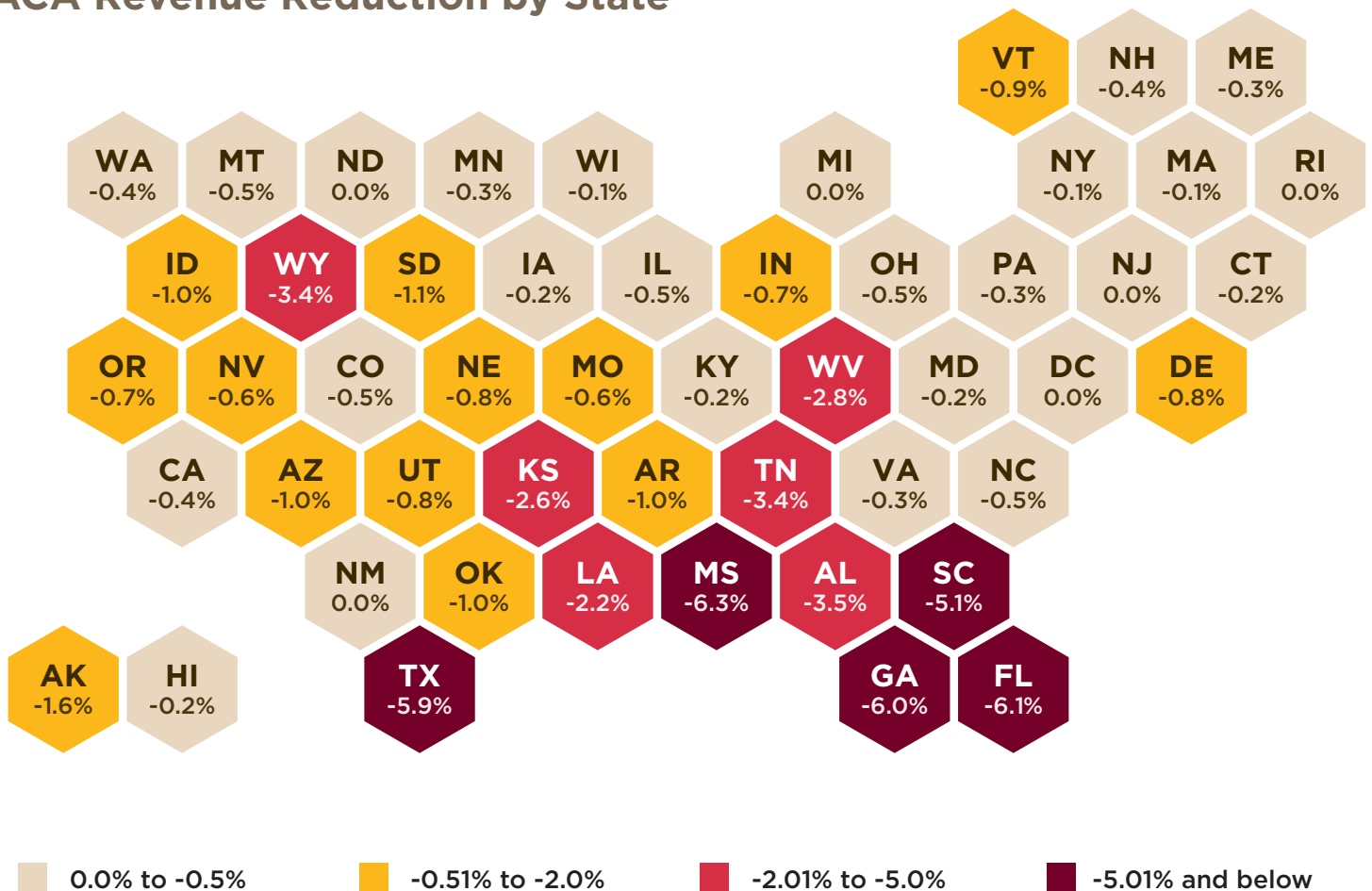
The ten most affected states are predominantly in the South and include several states without Medicaid expansion and where the ACA marketplace was the primary coverage vehicle for low-income working adults who did not qualify for Medicaid. The expiration of enhanced subsidies hits hardest precisely where there is no Medicaid

expansion backstop, compounding the Medicaid funding reductions from H.R. 1 in the same states and the same hospitals.

States highlighted in maroon represent reductions of 5 percent or greater — all of which are states where Medicaid was not expanded and where the ACA marketplace served as the primary coverage mechanism for low-income working adults. These states also account for a significant share of the 602 financially vulnerable hospitals: Florida (12), Georgia (10), Texas (35), Mississippi (19), South Carolina (7), Alabama (23), and Tennessee (17) together represent 123 hospitals, or over 20 percent of the total Financially Vulnerable cohort, while facing the steepest ACA-related revenue losses.

FIGURE 5

## ACA Revenue Reduction by State



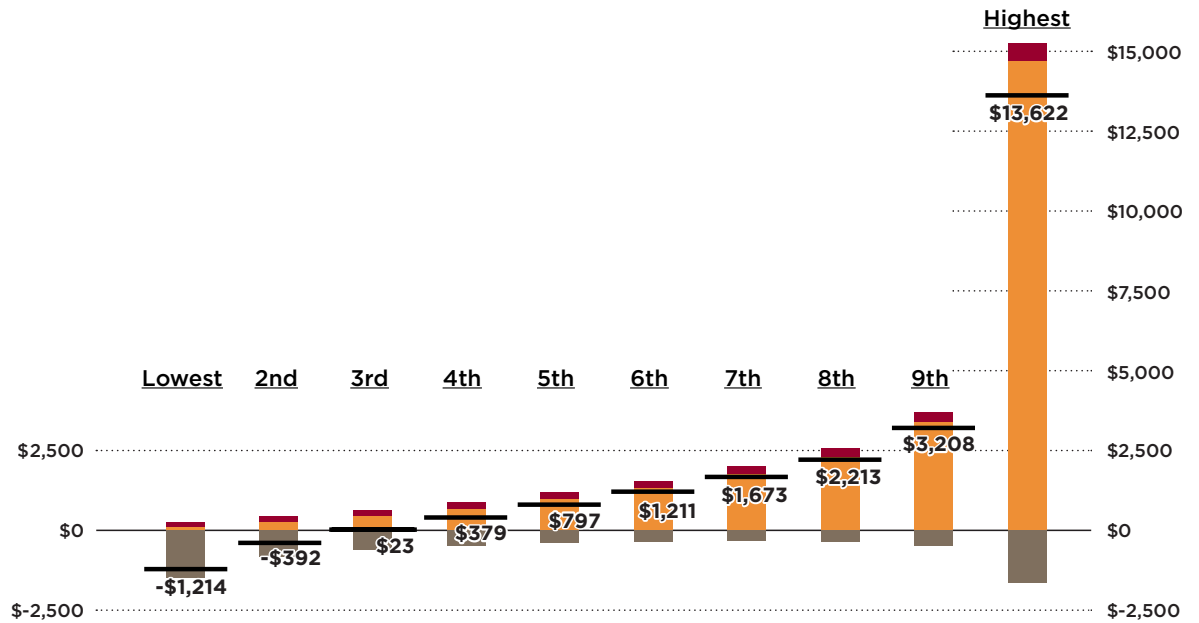
## APPENDIX D

# CBO Distributional Analysis of Public Law 119-21

The following figures present the Congressional Budget Office’s analysis of how the 2025 Reconciliation Act (Public Law 119-21) affects the distribution of resources available to households, by income decile.<sup>23</sup>

FIGURE 6

## Change in Household Resources (Dollars)

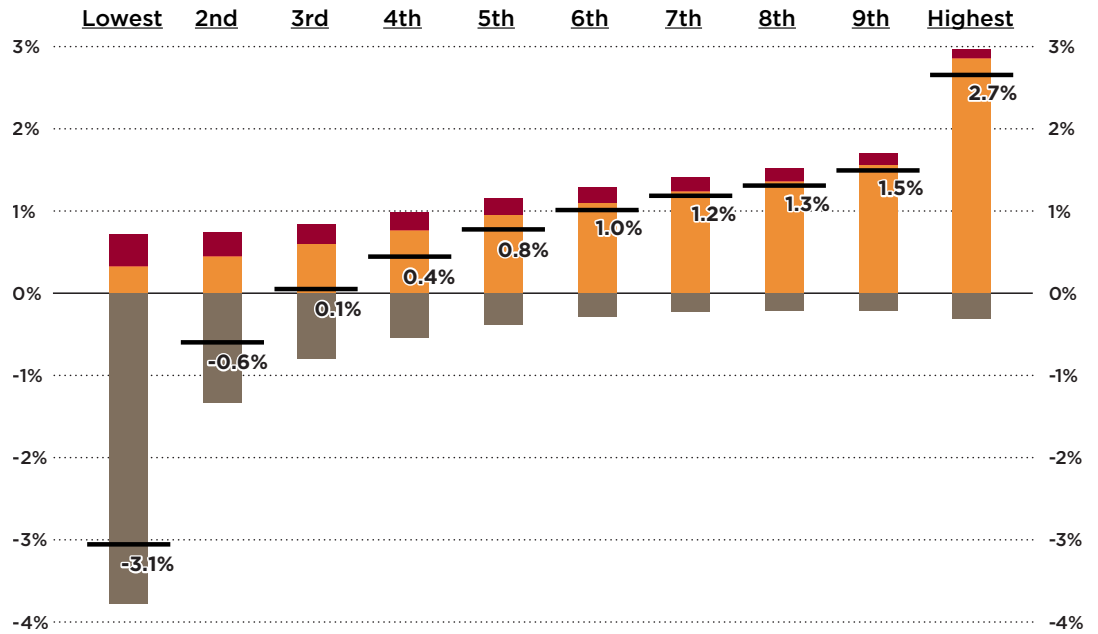


Household income decile	Lowest	2nd	3rd	4th	5th	6th	7th	8th	9th	Highest
■ Federal & State In-Kind Transfers	-\$1,485	-\$843	-\$610	-\$491	-\$406	-\$347	-\$332	-\$371	-\$478	-\$1,637
■ Federal Taxes & Cash Transfers	\$119	\$271	\$447	\$674	\$992	\$1,333	\$1,759	\$2,312	\$3,375	\$14,708
■ States' Fiscal Responses	\$8	\$7	\$7	\$7	\$7	\$7	\$8	\$9	\$10	\$13
■ Other Spending & Revenues	\$144	\$173	\$179	\$189	\$205	\$219	\$238	\$263	\$301	\$538
— Net Effect (black line)	-\$1,214	-\$392	\$23	\$379	\$797	\$1,211	\$1,673	\$2,213	\$3,208	\$13,622

Net effect values indicate a net loss in household resources. The lowest income decile experiences a net loss of 3.1 percent of household resources while the highest income decile gains 2.7 percent — reflecting the distributional consequences of H.R. 1’s combination of tax cuts and spending reductions.

FIGURE 7

## Change in Household Resources (Percent of Resources)



Household income decile	Lowest	2nd	3rd	4th	5th	6th	7th	8th	9th	Highest
■ Federal & State In-Kind Transfers	-3.8%	-1.3%	-0.8%	-0.5%	-0.4%	-0.3%	-0.2%	-0.2%	-0.2%	-0.3%
■ Federal Taxes & Cash Transfers	0.3%	0.4%	0.6%	0.8%	0.9%	1.1%	1.2%	1.4%	1.6%	2.9%
■ States' Fiscal Responses	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
■ Other Spending & Revenues	0.4%	0.3%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.1%	0.1%
— Net Effect (black line)	-3.1%	-0.6%	0.1%	0.4%	0.8%	1.0%	1.2%	1.3%	1.5%	2.7%

# APPENDIX E

## Financially Vulnerable Hospitals

● -7 ● -8 ● -9 ● -10

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
AL	Andalusia Regional Hospital	● -7	83	2,372
AL	Atmore Community Hospital	● -8	49	540
AL	Community Hospital	● -10	37	432
AL	DCH Regional Medical Center	● -8	472	23,914
AL	Decatur Morgan Hospital - Decatur Campus	● -10	310	8,402
AL	DeKalb Regional Medical Center	● -10	91	2,254
AL	DW McMillan Memorial Hospital	● -8	46	1,059
AL	Evergreen Medical Center	● -7	44	752
AL	Fayette Medical Center	● -8	34	539
AL	Grove Hill Memorial Hospital	● -10	21	176
AL	Helen Keller Hospital	● -8	178	6,362
AL	Highlands Medical Center	● -8	45	2,090
AL	Hill Hospital of Sumter County	● -9	33	320
AL	Jackson Hospital	● -9	278	13,824
AL	Lake Martin Community Hospital	● -10	46	533
AL	Lawrence Medical Center	● -8	43	395
AL	North Alabama Shoals Hospital	● -10	47	1,644
AL	North Mississippi Medical Center - Hamilton (Marion Regional Medical Center, Inc.)	● -10	36	321
AL	Prattville Baptist Hospital	● -10	49	2,815
AL	Russellville Hospital	● -9	49	743
AL	UAB St Vincents Birmingham	● -10	399	18,887
AL	UAB St Vincents Blount	● -10	25	858
AL	UAB St Vincents East	● -10	280	13,441
AZ	Abrazo Central Campus	● -7	154	5,412
AZ	Banner Boswell Medical Center	● -7	410	17,121
AZ	Banner Goldfield Medical Center	● -7	20	649
AZ	Dignity Health Arizona General Hospital - Mesa	● -10	50	4,144
AZ	HonorHealth Four Peaks Medical Center	● -9	139	1,180
AZ	HonorHealth Tempe Medical Center	● -7	74	486
AZ	Page Hospital	● -7	25	284
AR	Arkansas Methodist Medical Center	● -7	114	2,696
AR	Baptist Health - Fort Smith	● -9	279	10,636
AR	Baptist Health Medical Center - Conway	● -9	106	3,902
AR	CHI St Vincent Infirmiry	● -10	338	13,380
AR	CHI St Vincent Morrilton	● -8	25	460
AR	CHI St Vincent North	● -10	67	3,426
AR	Dardanelle Regional Medical Center	● -9	25	348
AR	Izard Regional Hospital	● -10	25	135
AR	Jefferson Regional Medical Center	● -8	245	6,551

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
AR	Johnson Regional Medical Center	● -7	59	1,794
AR	Little River Memorial Hospital	● -8	25	74
AR	Magnolia Regional Medical Center	● -8	29	757
AR	North Arkansas Regional Medical Center	● -8	120	2,028
AR	Ozarks Community Hospital	● -8	25	353
AR	Piggott Health System	● -8	25	828
AR	Saline Memorial Hospital	● -10	131	3,694
AR	South Arkansas Regional Hospital	● -8	105	2,969
CA	Adventist Health and Rideout	● -10	209	11,053
CA	Adventist Health Glendale	● -10	318	16,907
CA	Adventist Health Mendocino Coast	● -10	25	722
CA	Adventist Health Simi Valley	● -10	136	6,673
CA	Adventist Health St. Helena	● -10	141	3,547
CA	Adventist Health Tulare	● -10	73	1,624
CA	AHMC Anaheim Regional Medical Center	● -10	223	5,869
CA	AHMC Seton Medical Center	● -10	188	2,168
CA	Anaheim Global Medical Center	● -7	103	1,374
CA	Banner Lassen Medical Center	● -8	25	730
CA	California Pacific Medical Center - Mission Bernal Campu	● -8	120	5,309
CA	California Pacific Medical Center - Van Ness Campus	● -8	274	15,180
CA	Casa Colina Hospital and Center for Health Care	● -10	31	863
CA	Cedars-Sinai Marina Del Rey Hospital	● -8	103	4,489
CA	Chapman Global Medical Center	● -7	75	1,515
CA	Children's Hospital Los Angeles	● -7	386	18,559
CA	Chinese Hospital	● -7	58	1,134
CA	Coast Plaza Hospital	● -10	117	2,998
CA	Community Memorial Hospital - Ojai	● -10	25	378
CA	Dameron Hospital Association	● -10	170	2,937
CA	El Centro Regional Medical Center	● -9	161	3,194
CA	Encino Hospital Medical Center	● -7	82	1,382
CA	Garden Grove Hospital And Medical Center	● -7	167	3,156
CA	Garfield Medical Center	● -9	182	8,962
CA	Glendale Memorial Hospital and Health Center	● -10	241	8,686
CA	Glenn Medical Center	● -9	25	117
CA	Huntington Beach Hospital	● -8	82	2,211

# APPENDIX E Financially Vulnerable Hospitals

● -7 ● -8 ● -9 ● -10

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
CA	La Palma Intercommunity Hospital	● -7	115	2,984
CA	LAC/Harbor - UCLA Medical Center	● -7	381	20,177
CA	LAC/Olive View - Ucla Medical Center	● -8	238	11,326
CA	LAC/Rancho Los Amigos National Rehabilitation Center	● -7	58	1,255
CA	Loma Linda University Medical Center - Murrieta	● -10	111	10,506
CA	Los Angeles General Medical Center	● -7	545	29,727
CA	Mad River Community Hospital	● -8	49	778
CA	Martin Luther King, Jr. Community Hospital	● -7	152	9,468
CA	Memorialcare Miller Children's & Women's Hospital Long B	● -10	357	13,214
CA	Menifee Global Medical Center	● -10	84	3,329
CA	Methodist Hospital - Sacramento	● -8	154	9,097
CA	Mission Community Hospital - Panorama	● -10	145	5,653
CA	Palmdale Regional Medical Center	● -10	157	9,594
CA	Patients' Hospital Of Redding	● -9	10	58
CA	Petaluma Valley Hospital	● -10	58	1,758
CA	PIH Health Good Samaritan Hospital	● -8	308	10,736
CA	Providence Mission Hospital	● -8	311	17,019
CA	Providence Santa Rosa Memorial Hospital	● -8	233	11,517
CA	Providence St. Joseph Hospital	● -8	330	21,226
CA	Providence St. Joseph Hospital - Eureka	● -8	132	7,066
CA	Regional Medical Center Of San Jose	● -10	252	8,084
CA	Ridgecrest Regional Hospital	● -8	25	898
CA	Riverside University Health System Medical Center	● -7	423	23,670
CA	San Dimas Community Hospital	● -9	94	3,033
CA	San Geronio Memorial Hospital	● -9	79	2,820
CA	Scripps Mercy Hospital	● -7	550	29,041
CA	Shasta Regional Medical Center	● -8	118	5,970
CA	Sierra View Medical Center	● -7	128	5,306
CA	South Coast Global Medical Center	● -8	109	2,009
CA	St. Agnes Medical Center	● -8	401	27,211
CA	St. Bernardine - Medical Center	● -8	318	15,375
CA	St. Francis Memorial Hospital	● -10	171	2,753
CA	St. John'S Regional Medical Center	● -8	276	14,065

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
CA	St. Mary Medical Center - Long Beach	● -10	273	10,270
CA	St. Rose Hospital	● -10	171	3,337
CA	Stanislaus Surgical Hospital	● -8	23	218
CA	Tri-City Medical Center	● -7	252	8,635
CA	UCLA West Valley Medical Center	● -7	231	8,096
CA	USC Verdugo Hills Hospital	● -8	134	5,286
CA	Zuckerberg San Francisco General Hospital & Trauma Center	● -8	284	13,909
CO	Banner North Colorado Medical Center - Loveland Campus	● -9	101	1,951
CO	Banner North Colorado Medical Center	● -9	182	7,813
CO	Intermountain Health Lutheran Hospital	● -10	235	11,678
CO	Intermountain Health Platte Valley Hospital	● -8	89	3,788
CO	Longmont United Hospital	● -8	127	2,333
CO	CommonSpirit St. Elizabeth Hospital	● -9	19	947
CO	St Vincent General Hospital District	● -7	8	65
CO	UCHealth Broomfield Hospital	● -9	20	453
CO	UCHealth Grandview Hospital	● -10	22	311
CO	UCHealth Greeley Hospital	● -9	88	5,231
CO	UCHealth Highlands Ranch Hospital	● -8	139	7,644
CO	UCHealth Longs Peak Hospital	● -9	83	5,654
CT	Johnson Memorial Hospital	● -8	44	690
CT	Manchester Memorial Hospital	● -9	123	6,690
CT	Norwalk Hospital	● -8	186	8,788
CT	Sharon Hospital	● -10	36	1,009
CT	St Vincents Medical Center	● -8	222	12,670
CT	Waterbury Hospital	● -8	212	8,480
FL	AdventHealth North Pinellas	● -8	136	6,378
FL	Ascension Sacred Heart Hospital on the Gulf	● -10	19	335
FL	Bethesda Hospital East	● -10	367	18,866
FL	Halifax Health UF Health Medical Center of Deltona Hospital	● -10	43	2,458
FL	HCA Florida Highlands Hospital	● -9	109	3,790
FL	HCA Florida Pasadena Hospital	● -10	123	3,301
FL	Homestead Hospital	● -10	146	9,119
FL	Mease Dunedin Hospital	● -7	112	6,336
FL	Morton Plant North Bay Hospital	● -9	222	11,928
FL	North Shore Medical Center	● -9	730	4,628
FL	Parrish Medical Center	● -8	208	4,416
FL	UF Health Flagler Hospital	● -8	335	12,156
GA	Archbold Brooks	● -7	25	26

# APPENDIX E Financially Vulnerable Hospitals

● -7 ● -8 ● -9 ● -10

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
GA	Atrium Health Navicent Baldwin	● -10	86	3,211
GA	Donalsonville Hospital	● -8	41	486
GA	Early Medical Center	● -10	25	54
GA	Houston Healthcare - Warner Robins	● -8	267	13,844
GA	Memorial Satilla Health	● -7	130	6,725
GA	Mountain Lakes Medical Center	● -9	25	150
GA	Southwell Medical	● -8	8	162
GA	St Francis Emory Healthcare	● -9	310	11,972
GA	Stephens County Hospital	● -9	40	845
HI	Kau Hospital	● -9	21	1
HI	Kuakini Medical Center	● -8	170	3,639
ID	Idaho Falls Community Hospital	● -10	88	3,432
ID	St Joseph Regional Medical Center	● -9	102	3,252
ID	St Lukes Jerome Medical Center	● -9	16	179
IL	Ascension Saint Joseph Chicago	● -8	234	7,983
IL	Ascension St Alexius	● -8	313	17,535
IL	Carle Health Methodist Hospital	● -7	215	12,433
IL	Community First Medical Center	● -8	213	2,956
IL	Deaconess Illinois Crossroads	● -10	47	599
IL	Decatur Memorial Hospital	● -8	178	7,741
IL	Ferrell Hospital	● -7	25	375
IL	Franciscan Health Olympia Fields	● -10	105	8,442
IL	Holy Cross Hospital	● -8	153	5,014
IL	HSHS Holy Family Hospital	● -10	8	363
IL	HSHS St Marys Hospital	● -10	103	2,367
IL	Insight Hospital & Medical Center Chicago	● -8	72	2,663
IL	Northwestern Medicine Palos Hospital	● -10	326	20,505
IL	OSF Heart of Mary Medical Center	● -10	97	3,313
IL	OSF Sacred Heart Medical Center	● -10	100	2,637
IL	OSF Saint Anthonys Health Center	● -10	49	2,292
IL	OSF Saint Katharine Medical Center	● -8	80	2,556
IL	Provident Hospital of Cook County	● -8	34	910
IL	St Bernard Hospital	● -8	114	1,713
IL	Vista Medical Center East	● -10	166	4,532
IN	Bluffton Regional Medical Center	● -9	45	729
IN	Eskenazi Health	● -8	314	18,673
IN	Franciscan Health Rensselaer	● -8	25	297
IN	Good Samaritan Hospital	● -8	99	4,127
IN	Goshen Health Hospital	● -8	105	5,319

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
IN	Harrison County Hospital	● -8	25	751
IN	IU Health Frankfort Hospital	● -7	12	257
IN	IU Health Jay Hospital	● -8	21	449
IN	Johnson Memorial Hospital	● -7	58	1,856
IN	Lutheran Downtown Hospital	● -9	35	1,633
IN	Methodist Hospitals - Northlake	● -8	405	11,936
IN	Mishawaka Medical Center	● -7	253	11,826
IN	Monroe Hospital	● -10	32	1,334
IN	Norton Clark Hospital	● -10	153	7,426
IN	Norton Kings Daughters Health Hospital	● -10	70	2,267
IN	Norton Scott Hospital	● -9	21	293
IN	Parkview Logansport Hospital	● -8	37	1,289
IN	Riverview Health Noblesville Hospital	● -10	133	3,610
IN	St Elizabeth Dearborn Hospital	● -9	50	2,698
IN	Unity Physicians Hospital	● -8	29	342
IA	CHI Health Mercy Council Bluffs	● -7	141	6,510
IA	MercyOne Clinton Medical Center	● -8	107	2,469
IA	MercyOne Des Moines Medical Center	● -7	519	24,331
IA	MercyOne Newton Medical Center	● -10	48	610
IA	MercyOne North Iowa Medical Center	● -7	199	8,387
IA	Ottumwa Regional Health Center	● -10	76	1,643
IA	Southeast Iowa Regional Medical Center - West Burlington Campus	● -8	174	6,141
IA	UnityPoint Health - St Lukes Downtown	● -10	115	4,799
IA	University of Iowa Health Care Medical Center Downtown	● -8	171	5,141
KS	Allen County Regional Hospital	● -10	25	289
KS	Amberwell Atchison	● -8	25	886
KS	Anderson County Hospital	● -8	12	165
KS	Caldwell Regional Medical Center	● -8	25	66
KS	Community Memorial Healthcare	● -8	23	647
KS	Ellsworth County Medical Center	● -8	19	195
KS	Gove County Medical Center	● -8	21	249
KS	Holton Community Hospital	● -8	14	97
KS	Hutchinson Regional Medical Center	● -8	142	4,466
KS	Logan County Hospital	● -8	25	120
KS	Norton County Hospital	● -10	25	114
KS	Patterson Health Center	● -8	25	147
KS	Pratt Regional Medical Center	● -8	35	1,458
KS	Providence Medical Center	● -7	176	4,965

# APPENDIX E Financially Vulnerable Hospitals

● -7 ● -8 ● -9 ● -10

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
KS	Saint John Hospital	● -10	22	1,165
KS	Smith County Memorial Hospital	● -8	16	466
KS	Southwest Medical Center	● -8	67	2,101
KS	Stanton County Hospital	● -8	16	61
KS	Stevens County Hospital	● -8	17	107
KS	Susan B Allen Memorial Hospital	● -8	20	700
KS	The University of Kansas Health System - Great Bend Campus	● -10	29	1,098
KS	William Newton Hospital	● -8	25	1,115
KS	Wilson Medical Center	● -10	15	131
KY	The Medical Center at Russellville	● -9	37	329
LA	Acadian Medical Center	● -10	49	1,286
LA	CHRISTUS Ochsner St Patrick Hospital	● -8	100	5,845
LA	Glenwood Regional Medical Center	● -8	212	3,145
LA	Mercy Regional Medical Center	● -10	27	860
LA	New Orleans East Hospital	● -9	40	866
LA	Northern Louisiana Medical Center	● -10	122	2,855
LA	Oakdale Community Hospital	● -10	37	432
LA	Ochsner LSU Health Shreveport - Monroe Medical Center	● -10	87	4,196
LA	Ochsner St Mary	● -10	60	1,012
LA	Ochsner University Hospital & Clinics	● -9	52	2,570
LA	Opelousas General Health System - Main Campus	● -8	141	7,452
LA	University Medical Center New Orleans	● -10	326	13,540
LA	Winn Parish Medical Center	● -9	45	325
ME	MaineHealth Mid Coast Hospital	● -7	93	4,676
ME	Northern Light AR Gould Hospital	● -7	44	2,362
ME	St Marys Health System	● -10	140	3,181
ME	York Hospital	● -8	54	1,899
MA	Anna Jaques Hospital	● -8	116	4,766
MA	Athol Hospital	● -8	21	430
MA	Baystate Wing Hospital	● -8	41	3,580
MA	Heywood Hospital	● -9	114	3,321
MA	Mercy Medical Center	● -9	150	7,802
MA	Merrimack Health Methuen Hospital	● -7	293	6,335
MA	MerrimackHealth Lawrence Hospital	● -8	186	10,464
MA	Mount Auburn Hospital	● -8	189	11,270
MA	Tufts Medical Center	● -9	369	17,929
MA	UMass Memorial Health - Milford Regional Medical Center	● -8	148	10,413
MI	Aspirus Keweenaw Hospital	● -7	25	707

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
MI	Beacon Kalamazoo	● -10	239	11,019
MI	Healthsource Saginaw	● -7	7	257
MI	Insight Surgical Hospital	● -7	13	210
MI	MyMichigan Medical Center Saginaw	● -10	123	5,088
MI	MyMichigan Medical Center West Branch	● -7	88	2,013
MI	ProMedica Monroe Regional Hospital	● -7	147	5,231
MI	UM Health - Sparrow Carson	● -8	48	543
MI	UM Health - Sparrow Lansing	● -7	454	25,256
MI	UP Health System - Marquette	● -8	163	7,507
MN	Abbott Northwestern Hospital	● -8	605	33,298
MN	Allina Health Faribault Medical Center	● -7	32	1,461
MN	CHI LakeWood Health	● -8	15	138
MN	CHI St. Gabriel's Health	● -8	25	772
MN	Community Memorial Hospital	● -8	22	631
MN	Essentia Health - Graceville	● -10	15	71
MN	Fairview Range	● -8	73	2,126
MN	Hennepin Healthcare	● -10	347	14,252
MN	M Health Fairview St. John's Hospital	● -8	184	14,347
MN	Madelia Health	● -7	25	116
MN	Mayo Clinic Health System in Fairmont	● -8	37	1,001
MN	Mayo Clinic Health System in Lake City	● -8	18	170
MN	Mercy Hospital	● -8	468	29,042
MN	Mille Lacs Health System	● -8	18	274
MN	Northfield Hospital & Clinics	● -8	37	1,597
MN	River's Edge Hospital & Clinic	● -8	25	1,160
MN	RiverView Health	● -8	21	478
MN	Winona Health Services	● -8	49	1,293
MS	Baptist Anderson Regional Medical Center	● -10	270	8,012
MS	Baptist Memorial Hospital - Attala	● -7	25	347
MS	Baptist Memorial Hospital - Booneville	● -10	20	534
MS	Baptist Memorial Hospital - Yazoo	● -8	25	308
MS	Field Health System	● -8	16	126
MS	Greenwood Leflore Hospital	● -7	25	717
MS	Highland Community Hospital	● -10	49	1,112
MS	Marion General Hospital	● -9	49	322
MS	Merit Health Rankin	● -10	86	834
MS	North Mississippi Medical Center - Eupora	● -7	38	738
MS	North Mississippi Medical Center - Iuka	● -7	48	584
MS	North Sunflower Medical Center	● -10	25	274
MS	Ochsner Laird Hospital	● -9	25	96
MS	Ochsner Medical Center - Hancock	● -9	41	1,132

# APPENDIX E Financially Vulnerable Hospitals

● -7 ● -8 ● -9 ● -10

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
MS	Ochsner Stennis Hospital	● -7	25	62
MS	Pearl River County Hospital	● -10	24	9
MS	Singing River Gulfport	● -9	277	3,878
MS	Tippah County Hospital	● -7	25	293
MS	Winston Medical Center	● -8	14	259
MO	Bates County Memorial Hospital	● -8	40	294
MO	Boone Hospital Center	● -8	270	13,105
MO	Bothwell Regional Health Center	● -8	71	2,742
MO	Cameron Regional Medical Center	● -8	42	930
MO	Community Hospital Fairfax	● -8	16	334
MO	Fitzgibbon Hospital	● -8	42	1,262
MO	Hannibal Regional Hospital	● -8	86	5,121
MO	Lafayette Regional Health Center	● -10	25	759
MO	Liberty Hospital	● -8	199	7,727
MO	Mercy Hospital Southeast	● -8	232	6,380
MO	Nevada Regional Medical Center	● -8	41	679
MO	Ozarks Medical Center	● -8	111	4,496
MO	Pershing Memorial Hospital	● -7	25	139
MO	Ray County Hospital and Healthcare	● -8	25	159
MO	Research Medical Center	● -10	300	14,614
MO	Salem Memorial District Hospital	● -8	25	332
MO	Scotland County Hospital	● -10	25	420
MO	SSM Health Saint Louis University Hospital	● -9	382	16,904
MO	SSM Health St Joseph Hospital - St Charles	● -9	399	9,361
MO	SSM Health St Marys Hospital - Jefferson City	● -10	154	6,073
MO	St Joseph Medical Center	● -10	233	5,205
MO	University Health Lakewood Medical Center	● -8	117	4,409
MT	Bozeman Health Big Sky Medical Center	● -10	8	34
MT	Fallon Medical Complex	● -7	25	75
MT	Granite County Medical Center	● -9	25	18
MT	Phillips County Hospital	● -8	6	78
MT	Ruby Valley Medical Center	● -8	7	59
NE	Box Butte General Hospital	● -8	25	542
NE	CHI Health Midlands	● -8	28	1,181
NE	Dundy County Hospital	● -8	12	113
NE	Grand Island Regional Medical Center	● -7	60	1,355
NE	Morrill County Community Hospital	● -8	20	113
NE	Ogallala Community Hospital	● -8	18	256
NV	Dignity Health St Rose Dominican - San Martin Campus	● -10	118	6,837
NV	Humboldt General Hospital	● -7	25	503

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
NV	Mt Grant General Hospital	● -9	11	86
NV	Saint Marys Health Network	● -8	328	7,132
NH	Frisbie Memorial Hospital	● -10	39	1,077
NJ	Bayonne University Hospital	● -10	131	2,890
NJ	CareWell Health Medical Center	● -8	157	3,273
NJ	Cooper University Hospital Cape Regional	● -8	149	5,623
NJ	Heights University Hospital	● -10	163	3,709
NJ	Hoboken University Hospital	● -10	114	3,355
NJ	Newton Medical Center	● -8	139	6,922
NJ	RWJ University Hospital Rahway	● -7	139	4,807
NJ	Saint Michaels Medical Center	● -10	110	5,922
NJ	Trinitas Regional Medical Center - Williamson Street Campus	● -8	182	9,440
NM	Covenant Health Hobbs Hospital	● -10	27	1,442
NM	Lovelace Medical Center	● -10	277	11,959
NM	Presbyterian Hospital	● -7	772	42,768
NM	Presbyterian Santa Fe Medical Center	● -9	36	2,324
NY	Adirondack Medical Center - Saranac Lake	● -7	83	1,831
NY	Arnot Ogden Medical Center	● -7	191	7,876
NY	Bassett Medical Center	● -8	180	8,925
NY	Brookdale University Hospital Medical Center	● -10	450	18,673
NY	Champlain Valley Physicians Hospital	● -8	286	7,539
NY	Columbia Memorial Health	● -8	192	3,340
NY	Ellis Hospital	● -8	270	11,931
NY	Erie County Medical Center	● -10	410	15,096
NY	Garnet Health Medical Center	● -8	329	19,369
NY	Garnet Health Medical Center - Catskills	● -8	76	2,511
NY	Geneva General Hospital	● -8	117	2,538
NY	Good Samaritan Hospital	● -7	286	13,502
NY	Guthrie Lourdes Hospital	● -10	175	8,098
NY	HealthAlliance Hospital Marys Ave Campus	● -10	124	6,394
NY	Jamaica Hospital Medical Center	● -10	275	14,050
NY	Maimonides Medical Center	● -8	641	28,282
NY	Margaretville Hospital	● -10	15	94
NY	Mercy Hospital	● -10	166	9,156
NY	Mercy Hospital of Buffalo	● -9	364	17,840
NY	Mount Sinai Brooklyn	● -9	377	14,741
NY	Mount Sinai Morningside	● -9	644	36,914
NY	Nathan Littauer Hospital	● -8	57	2,026
NY	New York Eye and Ear Infirmary of Mount Sinai	● -8	12	304
NY	NewYork-Presbyterian Hudson Valley Hospital	● -7	128	7,937

# APPENDIX E Financially Vulnerable Hospitals

● -7 ● -8 ● -9 ● -10

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
NY	NuHealth - Nassau University Medical Center	● -10	372	11,649
NY	NYU Langone Hospital - Suffolk	● -8	157	9,566
NY	Olean General Hospital	● -8	202	5,573
NY	Oneida Health Hospital	● -7	101	2,250
NY	Orleans Community Health - Medina Memorial Hospital	● -8	25	157
NY	Peconic Bay Medical Center	● -7	130	10,447
NY	Putnam Hospital	● -8	86	2,549
NY	St Anthony Community Hospital	● -8	60	1,620
NY	St Catherine of Siena Hospital	● -10	163	8,786
NY	St Charles Hospital	● -10	140	8,358
NY	St Johns Riverside Hospital - Andrus Pavilion	● -9	319	14,329
NY	St Joseph Hospital	● -10	121	6,704
NY	St Marys Hospital - Hospital Campus	● -8	100	3,308
NY	Stony Brook University Hospital	● -7	725	37,659
NY	The Mount Sinai Hospital	● -7	1,046	57,509
NY	Wyckoff Heights Medical Center	● -10	240	11,735
NC	Angel Medical Center	● -9	30	1,775
NC	Blue Ridge Regional Hospital	● -10	25	1,764
NC	Chatham Hospital	● -9	25	1,156
NC	Frye Regional Medical Center	● -7	226	7,398
NC	Highlands-Cashiers Hospital	● -10	24	660
NC	Mission Hospital McDowell	● -8	43	2,223
NC	Northern Regional Hospital	● -7	100	3,548
NC	Person Memorial Hospital	● -10	38	599
NC	Transylvania Regional Hospital	● -7	25	1,505
NC	UNC Rockingham Health Care	● -10	108	1,759
ND	CHI Lisbon Health	● -8	25	86
ND	CHI Oakes Hospital	● -7	20	132
ND	CHI St Alexius Health Garrison Hospital	● -8	22	205
ND	CHI St Alexius Health Turtle Lake Hospital	● -8	25	87
ND	Essentia Health - Fargo	● -8	142	9,398
ND	Jacobson Memorial Hospital & Care Center	● -8	25	53
ND	Southwest Healthcare Services	● -7	35	66
ND	St Lukes Medical Center	● -9	20	71
ND	Trinity Hospital	● -7	107	7,359
OH	Euclid Hospital	● -10	90	4,807
OH	Fulton County Health Center	● -7	25	1,100
OH	Harrison Community Hospital	● -8	25	210
OH	Kettering Health Greene Memorial	● -10	13	632
OH	Knox Community Hospital	● -7	64	3,294
OH	Mercy Health - Lorain Hospital	● -10	145	7,753
OH	Mount Carmel East	● -8	523	29,498

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
OH	Ohio State University Wexner Medical Center	● -10	968	46,347
OH	OhioHealth Van Wert Hospital	● -7	27	851
OH	Parkview Montpelier Hospital	● -9	25	12
OH	South Pointe Hospital	● -10	172	7,253
OH	Trinity Hospital Twin City	● -8	25	98
OH	UC Health West Chester Hospital	● -7	154	11,046
OK	Carnegie Tri-County Municipal Hospital	● -10	17	165
OK	Great Plains Regional Medical Center	● -8	42	870
OK	Harmon Memorial Hospital	● -10	22	81
OK	Haskell Regional Hospital	● -8	25	50
OK	Hillcrest Hospital Cushing	● -10	28	562
OK	Hillcrest Hospital Henryetta	● -10	15	561
OK	INTEGRIS Community Hospital - Council Crossing	● -9	32	348
OK	INTEGRIS Health Grove Hospital	● -8	41	1,553
OK	INTEGRIS Miami Hospital	● -10	32	1,192
OK	Jackson County Memorial Hospital	● -7	49	1,672
OK	Mangum Regional Medical Center	● -10	18	193
OK	McAlester Regional Health Center	● -8	67	2,585
OK	Memorial Health Southwest	● -10	126	2,317
OK	Memorial Hospital of Texas County	● -8	6	121
OK	Norman Regional Hospital	● -8	289	14,727
OK	Okeene Municipal Hospital	● -8	17	50
OK	Pawhuska Hospital	● -7	25	103
OK	Prague Regional Memorial Hospital	● -9	25	29
OK	Purcell Municipal Hospital	● -7	10	165
OK	Roger Mills Memorial Hospital	● -8	15	263
OK	Rural Wellness Anadarko	● -8	25	129
OK	Rural Wellness Fairfax	● -10	25	58
OK	Rural Wellness Stroud	● -8	25	46
OK	SSM Health St Anthony Hospital - Midwest	● -9	164	7,281
OK	St Marys Regional Medical Center	● -8	142	3,443
OK	Surgical Hospital of Oklahoma	● -10	12	333
OK	Wagoner Community Hospital	● -10	100	1,868
OR	Adventist Health Portland	● -8	168	9,624
OR	Bay Area Hospital	● -8	144	4,997
OR	Good Samaritan Regional Medical Center	● -8	169	8,213
OR	Harney District Hospital	● -8	24	312
OR	Lake District Hospital	● -10	24	365
OR	Legacy Emanuel Medical Center	● -10	400	19,346
OR	Legacy Mount Hood Medical Center	● -8	100	5,147

# APPENDIX E Financially Vulnerable Hospitals

● -7 ● -8 ● -9 ● -10

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
OR	Legacy Silverton Medical Center	● -10	29	2,385
OR	Salem Hospital	● -8	537	25,753
OR	Samaritan Albany General Hospital	● -7	67	2,149
OR	Willamette Valley Medical Center	● -8	50	2,406
PA	Bucktail Medical Center	● -9	16	57
PA	Chester County Hospital	● -8	309	20,941
PA	Conemaugh Health System - Conemaugh Memorial Medical Center Main Campus	● -10	260	15,886
PA	Conemaugh Health System - Conemaugh Meyersdale Medical Center	● -8	20	136
PA	Heritage Valley Beaver	● -8	126	7,932
PA	Heritage Valley Sewickley	● -7	165	4,248
PA	Jefferson Abington Hospital	● -8	611	35,357
PA	Nazareth Hospital	● -10	132	6,845
PA	Penn Highlands Huntingdon	● -10	77	2,235
PA	Phoenixville Hospital	● -10	130	7,650
PA	Pottstown Hospital	● -10	185	6,670
PA	Redeemer Health	● -8	213	8,272
PA	Regional Hospital of Scranton	● -10	177	7,780
PA	St Lukes Grand View Campus	● -8	193	9,182
PA	Suburban Behavioral Health Campus of Roxborough Memorial Hospital	● -10	60	1,557
PA	Temple Health - Chestnut Hill Hospital	● -7	128	6,676
PA	UPMC Cole	● -8	25	808
PA	UPMC McKeesport	● -8	123	4,052
PA	UPMC Passavant - McCandless	● -8	365	15,173
PA	UPMC St Margaret	● -8	170	7,873
PA	Valley Forge Medical Center and Hospital	● -10	70	2,434
PA	Wills Eye Hospital	● -7	4	235
RI	Our Lady of Fatima Hospital	● -10	185	3,367
RI	Roger Williams Medical Center	● -10	148	5,289
RI	Westerly Hospital	● -10	70	3,393
SC	Abbeville Area Medical Center	● -8	25	355
SC	Allendale County Hospital	● -7	25	185
SC	MUSC Health Chester Medical Center	● -10	33	821
SC	MUSC Health Kershaw Medical Center	● -10	69	2,714
SC	MUSC Health Marion Medical Center	● -10	28	931
SC	Prisma Health Baptist Hospital	● -7	230	11,528
SC	Prisma Health Richland Hospital	● -10	603	27,032
SD	Avera Gregory Hospital	● -8	13	204
SD	Avera St Lukes Hospital	● -8	50	2,778
SD	Winner Regional Hospital	● -7	25	755

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
TN	Ascension Saint Thomas Hickman	● -8	60	91
TN	Baptist Memorial Hospital - Carroll County	● -10	35	1,090
TN	CHI Memorial Hospital Chattanooga	● -7	431	22,525
TN	Claiborne Medical Center	● -8	26	1,093
TN	Cumberland Medical Center	● -8	82	5,065
TN	Holston Valley Medical Center	● -8	303	14,222
TN	Houston County Community Hospital	● -9	25	101
TN	Lincoln Medical Center	● -8	47	1,037
TN	Livingston Regional Hospital	● -8	88	1,508
TN	Methodist Medical Center of Oak Ridge	● -8	156	8,961
TN	Methodist University Hospital	● -7	1,368	50,828
TN	Regional Medical Center	● -8	291	13,913
TN	Saint Francis Hospital - Memphis	● -8	340	15,513
TN	Sweetwater Hospital Association	● -7	55	2,080
TN	TriStar NorthCrest Medical Center	● -10	109	3,481
TN	West Tennessee Healthcare Dyersburg Hospital	● -9	109	2,401
TN	West Tennessee Healthcare Volunteer Hospital	● -9	20	998
TX	Baylor Scott & White Medical Center - Taylor	● -8	25	418
TX	Big Bend Regional Medical Center	● -8	25	436
TX	CHI St Joseph Regional Health Care Center	● -8	284	15,434
TX	CHI St Lukes Health - Patients Medical Center	● -10	46	2,948
TX	CHI St Lukes Health - Sugar Land Hospital	● -10	100	5,311
TX	CHI St Lukes Health - The Vintage Hospital	● -10	102	5,436
TX	CHI St Lukes Health-Memorial Lufkin	● -10	152	7,735
TX	Cogdell Memorial Hospital	● -7	25	466
TX	Columbus Community Hospital	● -8	40	983
TX	Concho County Hospital	● -8	16	34
TX	Covenant Medical Center	● -8	439	18,504
TX	Dallas Medical Center	● -10	119	3,903
TX	Ennis Regional Medical Center	● -10	59	463
TX	Haskell Memorial Hospital	● -7	25	52
TX	HCA Houston Healthcare Pearland	● -10	48	4,374
TX	Lamb Healthcare Center	● -8	42	234
TX	Medical City Decatur	● -10	97	2,224
TX	Methodist Charlton Medical Center	● -7	296	14,043
TX	Methodist Midlothian Medical Center	● -7	62	2,313

# APPENDIX E Financially Vulnerable Hospitals

● -7 ● -8 ● -9 ● -10

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
TX	Methodist Southlake Medical Center	● -10	22	498
TX	Mitchell County Hospital	● -7	25	122
TX	North Runnels Hospital	● -7	12	138
TX	Northwest Hills Surgical Hospital	● -9	8	404
TX	OakBend Medical Center - Jackson Street Hospital Campus	● -8	158	2,895
TX	Rolling Plains Memorial Hospital	● -8	40	462
TX	Seton Medical Center Harker Heights	● -7	65	3,529
TX	Shamrock General Hospital	● -10	25	20
TX	St Joseph Medical Center	● -8	156	6,502
TX	Swisher Memorial Hospital	● -8	20	42
TX	The Medical Center of Southeast Texas	● -7	196	3,402
TX	The Woodlands Specialty Hospital	● -9	6	166
TX	TMC Bonham Hospital	● -8	25	415
TX	Val Verde Regional Medical Center	● -7	47	1,733
TX	W J Mangold Memorial Hospital	● -7	25	100
TX	White Rock Medical Center	● -10	64	1,807
UT	Cache Valley Hospital	● -10	28	635
UT	Holy Cross Hospital Salt Lake	● -9	85	885
VA	Bon Secours - Southampton Medical Center	● -8	42	942
VA	Buchanan General Hospital	● -8	111	914
VA	Carilion Giles Community Hospital	● -7	25	1,185
VA	Carilion Tazewell Community Hospital	● -10	23	662
VA	Centra Southside Community Hospital	● -7	77	2,792
VA	Sentara Halifax Regional Hospital	● -8	44	2,441
VA	Southern Virginia Regional Medical Center	● -8	39	432
VA	Twin County Regional Hospital	● -7	141	1,872
VA	VCU Health Community Memorial Hospital	● -7	70	3,935
VA	VCU Health Tappahannock Hospital	● -7	37	1,926
WA	Astria Toppenish Hospital	● -10	45	707
WA	East Adams Rural Hospital	● -8	12	40
WA	EvergreenHealth Medical Center	● -7	340	17,450
WA	Forks Community Hospital	● -10	25	160
WA	MultiCare Auburn Medical Center	● -10	91	7,390
WA	MultiCare Capital Medical Center	● -10	85	5,061
WA	MultiCare Deaconess Hospital	● -10	319	11,312

State	Hospital Name	Financial Vulnerability Score	# Beds	# Discharges
WA	MultiCare Good Samaritan Hospital	● -8	314	19,968
WA	Olympic Medical Center	● -8	78	3,695
WA	Overlake Medical Center & Clinics	● -7	303	18,265
WA	St Joseph Medical Center	● -9	360	22,336
WA	Trios Southridge Hospital	● -8	111	5,159
WA	Virginia Mason Medical Center	● -8	199	11,937
WV	CAMC General Hospital	● -7	803	32,813
WV	CAMC Greenbrier Valley Medical Center	● -9	66	2,800
WV	Davis Medical Center	● -10	90	2,388
WV	Grafton City Hospital	● -9	25	131
WV	Raleigh General Hospital	● -8	300	8,473
WV	Rivers Health	● -10	43	844
WV	Webster Memorial Hospital	● -8	25	78
WI	Ascension Columbia St Marys Hospital Milwaukee	● -8	360	12,833
WI	Ascension St Francis Hospital	● -8	73	1,986
WI	Aspirus Divine Savior Hospital	● -8	42	1,391
WI	Aspirus Wisconsin Rapids Hospital	● -7	38	3,317
WI	Aurora Medical Center - Bay Area	● -8	60	2,652
WI	Howard Young Medical Center	● -7	42	1,304
WI	Marshfield Medical Center - Eau Claire	● -10	56	3,235
WI	Marshfield Medical Center - Marshfield	● -10	218	13,187
WI	Marshfield Medical Center - Minocqua	● -10	31	1,239
WI	Marshfield Medical Center - Weston	● -10	99	3,958
WI	Marshfield Medical Center Beaver Dam	● -8	43	999
WY	Campbell County Memorial Hospital	● -8	66	2,357
WY	Memorial Hospital of Carbon County	● -8	25	208
WY	SageWest - Riverton	● -8	133	1,848
WY	South Lincoln Medical Center	● -8	14	74
WY	Weston County Health Services	● -8	12	135

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