

California hospitals

Executive summary

- 1 The 299 comparable general acute care hospitals had 71,732 licensed beds and 2.78 million inpatient discharges in 2024.
- 2 Operating margin was 1.7% and net income margin was 6.6%. Of the 299 hospitals, 141 lost money on operations and 97 had a net loss.
- 3 Of the 61 hospitals that received at least half of their net patient revenue from Medi-Cal, 39 had operating losses and 21 had net losses.
- 4 In the median county, inpatient market concentration (HHI) is 1,986 with hospitals counted separately and 2,553 with hospitals grouped by health system.
- 5 California hospitals scored higher than the U.S. average on sepsis care (68.8% vs. 63.6%) but had longer ED stays (183 vs. 170 minutes) and fewer patients who would definitely recommend them.
- 6 Medi-Cal provided 30.3% of net patient revenue (\$44.30 billion). A 3% cut to that revenue would equal \$1.33 billion.

These findings describe the state as a whole. Access problems are local, so the regional, county and hospital pages matter as much as the statewide totals.

Notes: Draft release by CRWDHEALTH LLC. Not a CHCF publication. AI tools assisted with code, drafting and the cover artwork.

[1] HCAI Hospital Annual Selected File, calendar year 2024 (April 2026 extract)

[2] HCAI Patient Origin and Market Share, 2024

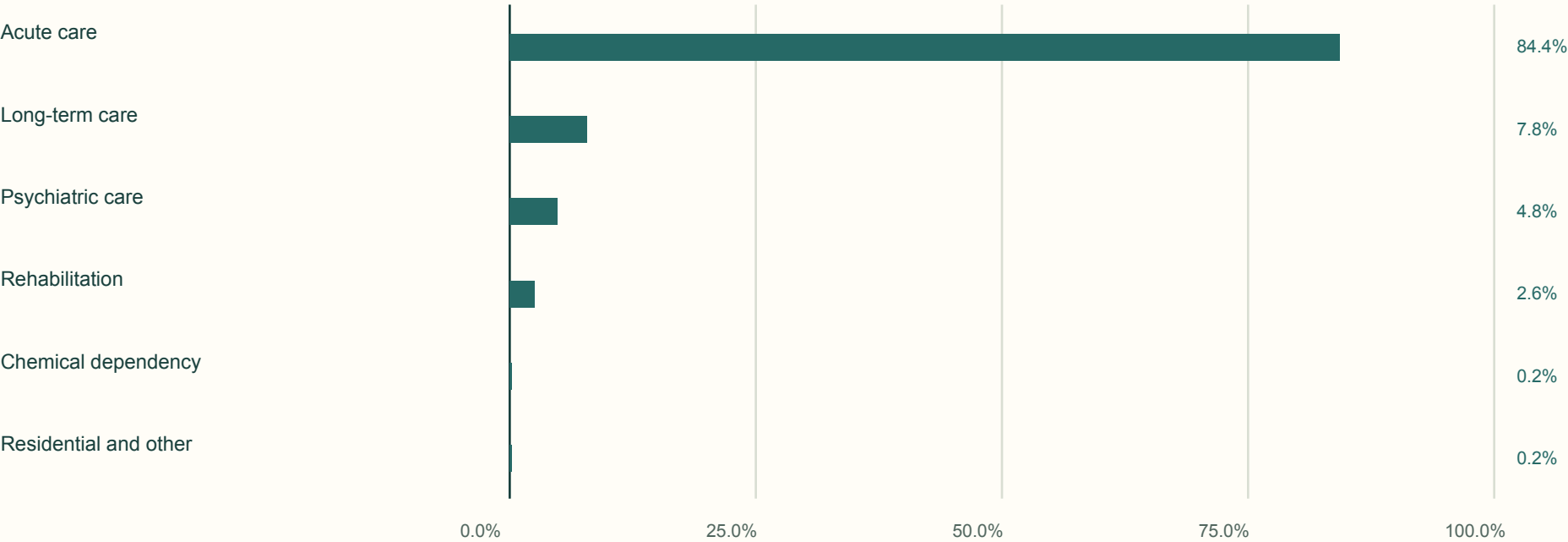
[3] CMS Hospital General Information, HCAHPS and Timely and Effective Care, August 2026 snapshots

[4] DHCS Medi-Cal Financing and Federal Register rule status, rechecked September 26, 2026

Licensed beds by type of care

Acute care accounts for 84.4% of licensed beds.

Share of licensed beds



The 299 hospitals report 71,732 licensed beds, 68,429 available beds and 46,825 staffed beds. Each is a different measure of capacity, so they should not be added together. Long-term and psychiatric care account for 9,073 licensed beds inside these general acute hospitals.

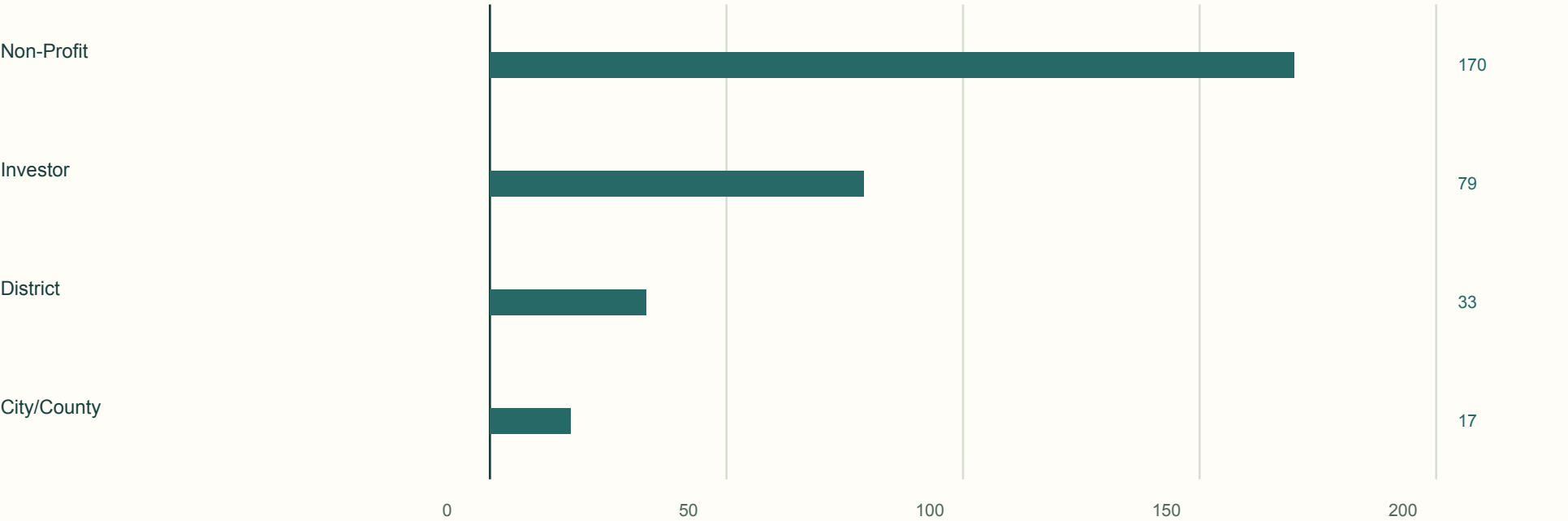
Notes: Types of care follow HCAI's classification within general acute hospitals. Licensed beds are counted at the end of the reporting period and exclude suspended beds and nursery bassinets. Discharges include transfers between types of care. Figures may not sum due to rounding.

[1] HCAI Hospital Annual Selected File, calendar year 2024 (April 2026 extract)

Ownership and licensed beds

Nonprofit hospitals make up 56.9% of hospitals and hold 64.8% of licensed beds.

Hospitals



Of the 299 hospitals, 170 are nonprofit. The rest are 79 investor-owned, 33 district and 17 city or county hospitals. Type of control describes legal ownership. On its own, it says nothing about charity care or financial health.

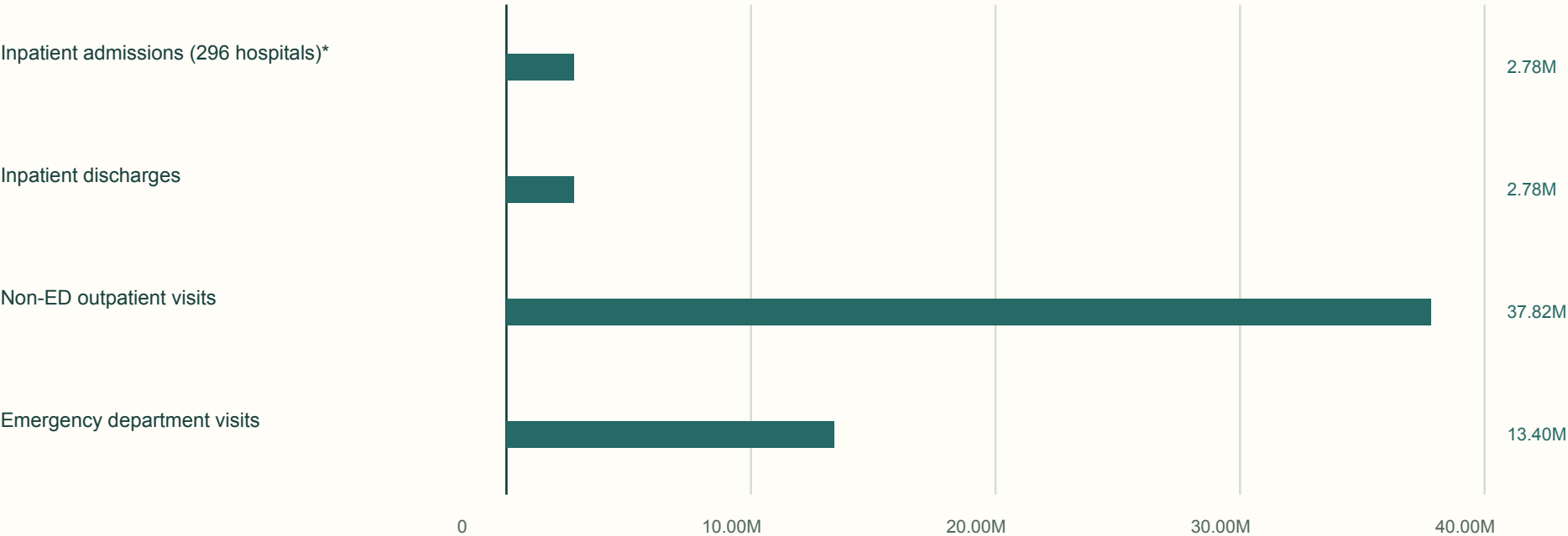
Notes: Type of control as reported to HCAI. The chart shows hospital counts; the table also shows licensed beds.

[1] HCAI Hospital Annual Selected File, calendar year 2024 (April 2026 extract)

Use of hospital services

Emergency departments accounted for 26.2% of outpatient visits.

Encounters



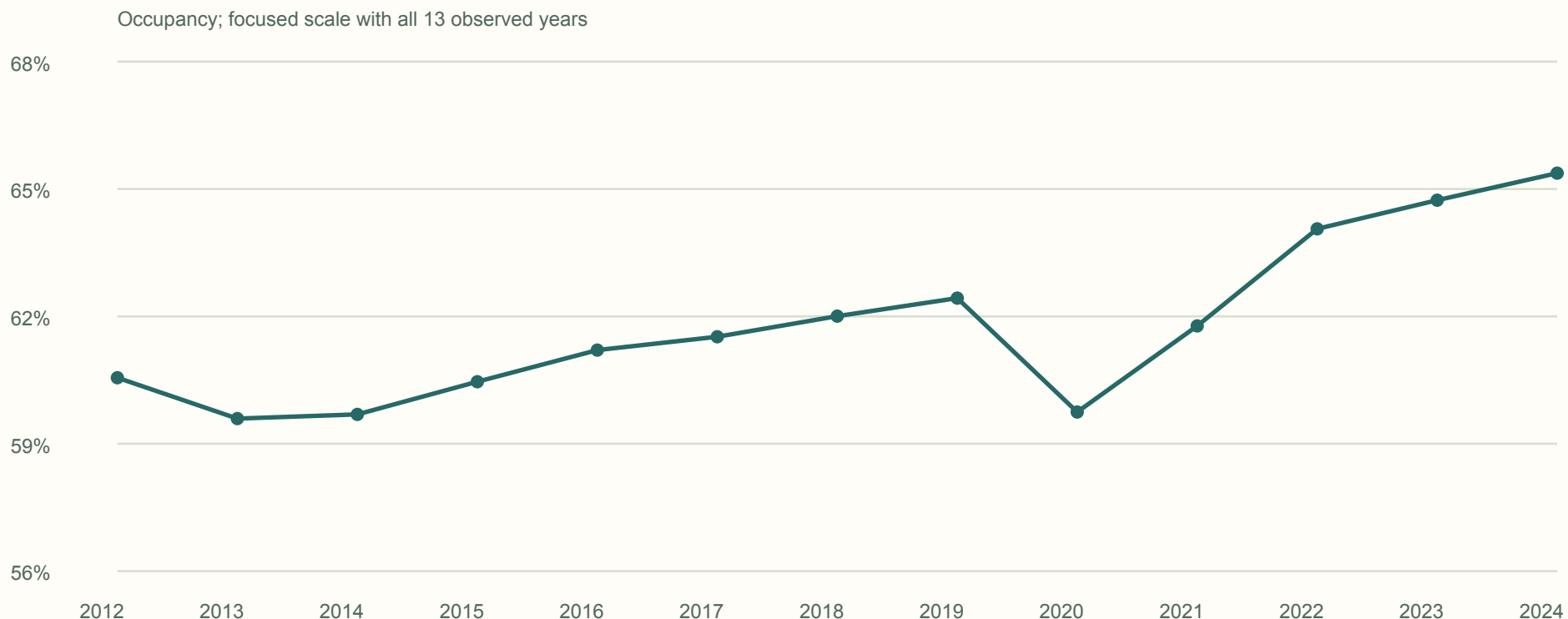
Hospitals reported 51.22 million outpatient visits, 13.40 million of them in emergency departments (EDs). Available-bed occupancy was 65.0%. At the 296 hospitals that reported admissions, admissions were 100.2% of discharges.

Notes: *Admissions come from each hospital's 2024 annual disclosure report in HCAI's SIERA system (page 18, column 13, line 170), matched on reporting period. 3 hospitals left the line blank and are shown as missing. Admissions exclude nursery admissions and in-house transfers. Discharges include deaths and transfers between types of care. Non-ED visits are outpatient visits minus ED visits.

[1] HCAI Hospital Annual Selected File, calendar year 2024 (April 2026 extract)
[2] HCAI SIERA hospital annual disclosure reports, 2024 periods (revised versions)
[3] HCAI Accounting Manual, Chapter 7000, page 18 admissions unit

Available-bed occupancy, 2012 to 2024

Occupancy has risen since 2012.



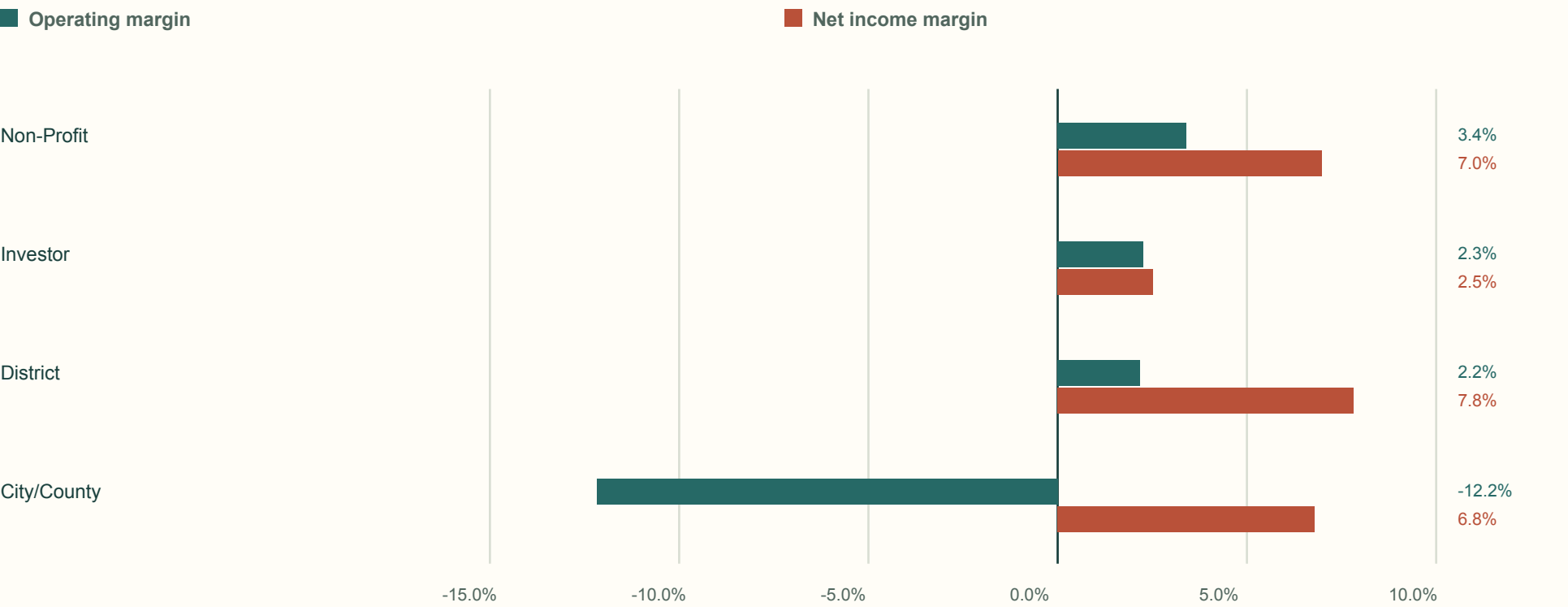
Available-bed occupancy rose from 60.3% in 2012 to 65.0% in 2024. The change reflects patient volume, the number of available beds and which hospitals were in each year's cohort. It does not show how individual hospitals changed.

Notes: The trend uses 13 annual snapshots. Each year uses that year's comparable general acute cohort, so closures, mergers and reporting changes affect the trend. Dollar values in the supporting data are not adjusted for inflation.

[1] HCAI Hospital Annual Selected Files, 2012–2024; each year's comparable GAC cohort

Operating and net income margins

Net income was much stronger than operating results.



Hospitals earned \$2.61 billion from operations and \$10.64 billion in net income, after \$11.01 billion in nonoperating revenue, \$2.86 billion in nonoperating expense and \$0.13 billion in income taxes. Of the 141 hospitals with operating losses, 46 still had positive net income.

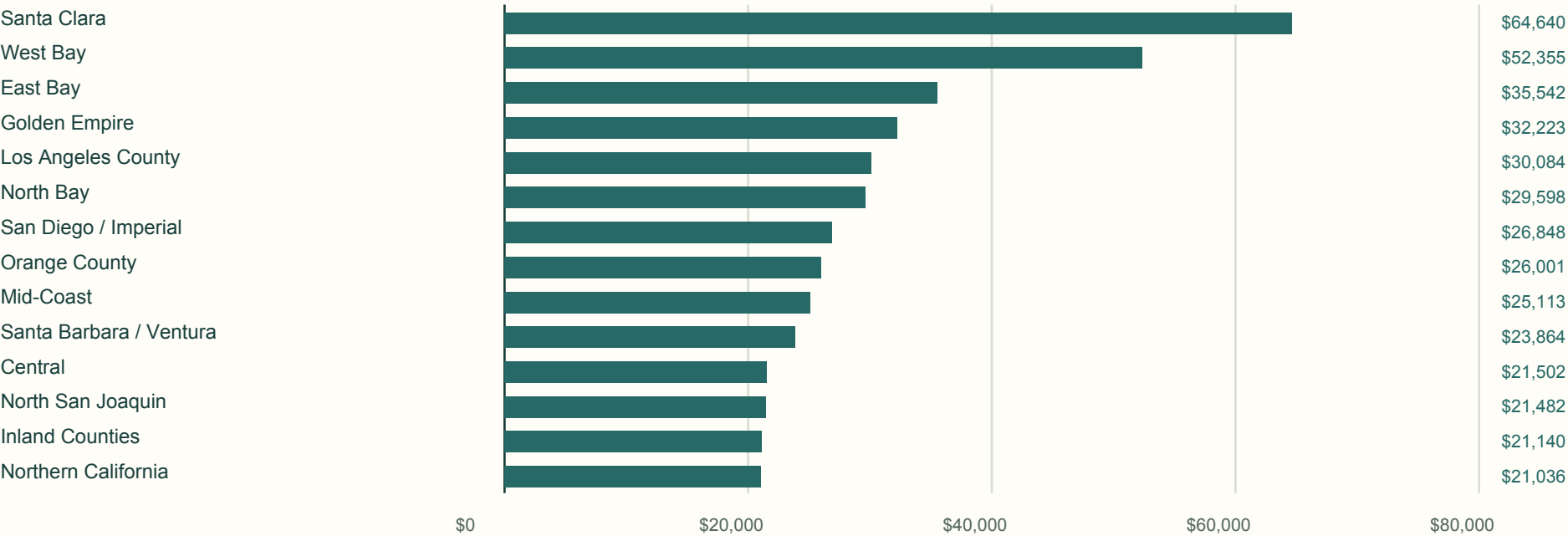
Notes: Operating margin is the operating result divided by operating revenue. Net income margin is net income divided by total revenue, including nonoperating revenue. Both use summed dollars for all 299 hospitals. Nonoperating revenue includes investment income and may not recur. Hospital-level figures are in financial_position.csv.

[1] HCAI Hospital Annual Selected File, calendar year 2024 (April 2026 extract)

Operating cost by region

Cost per adjusted discharge ranged from \$21,036 in Northern California to \$64,640 in Santa Clara.

Cost per adjusted discharge



Hospitals spent \$147.90 billion on operations in 2024, or \$29,734 per adjusted discharge. Regional differences reflect the services hospitals offer, local wages, patient mix and accounting practices, as well as efficiency.

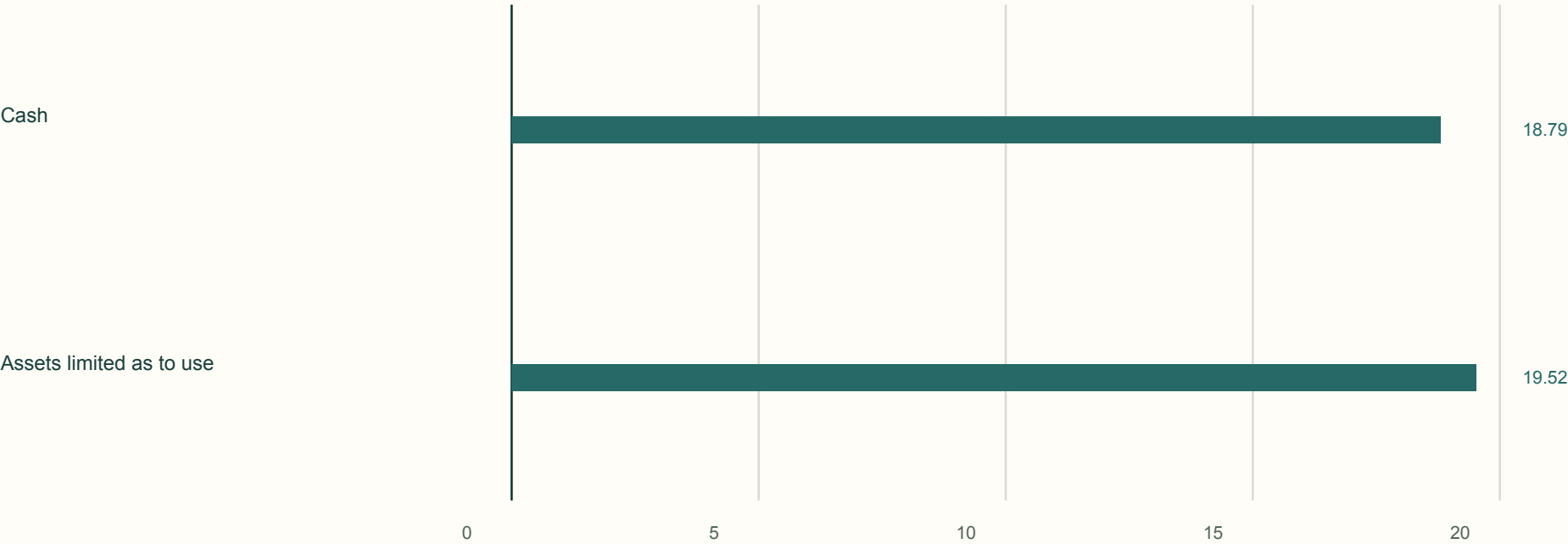
Notes: Operating expense divided by HCAI adjusted discharges, which convert outpatient activity to inpatient equivalents using revenue. Adjusted discharges are not adjusted for patient risk. Only hospitals reporting both values are included.

[1] HCAI Hospital Annual Selected File, calendar year 2024 (April 2026 extract)

Reserves and liquidity

Reported reserves covered 98 days of operating expense.

USD billions



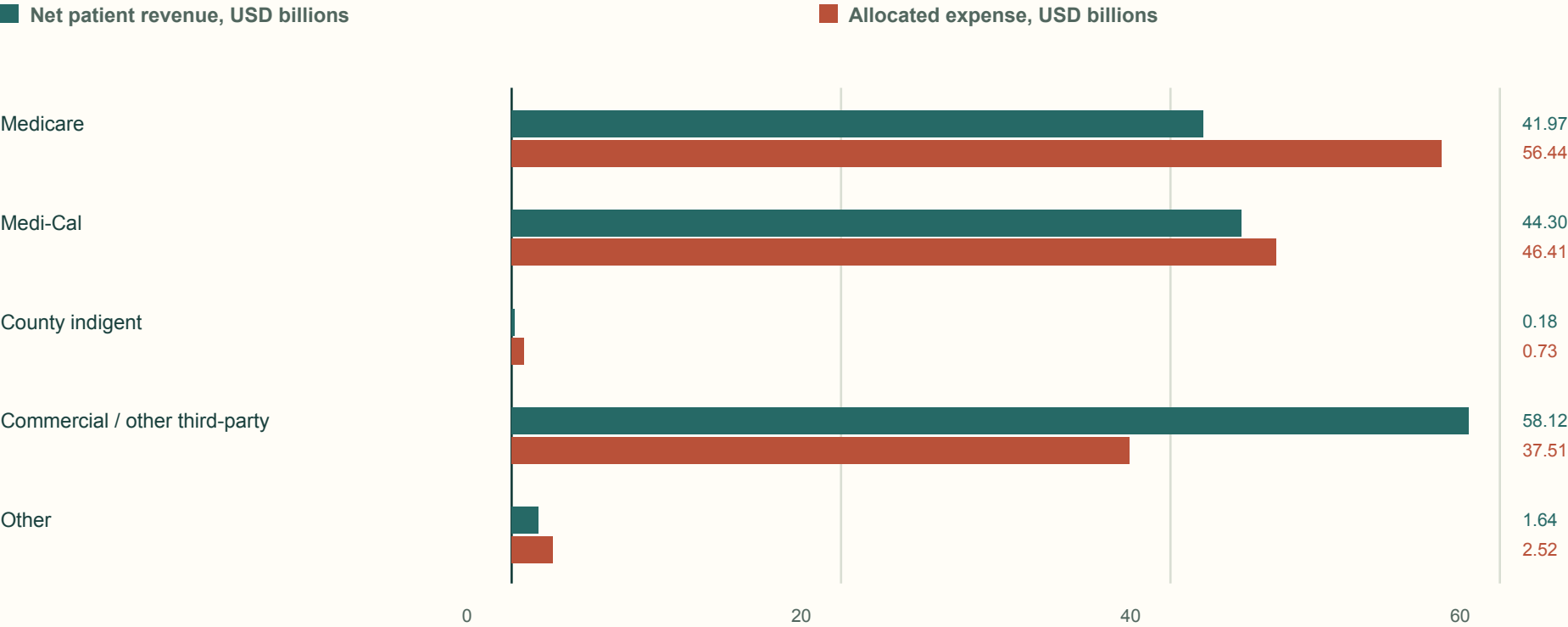
Cash and assets limited as to use totaled \$38.31 billion, enough to cover 97.7 days of operating expense excluding depreciation. Some of these assets are restricted, so the figure overstates unrestricted days cash on hand. Hospitals in systems may also hold cash at the parent level.

Note: Reserve days equal cash plus assets limited as to use, divided by daily operating expense excluding depreciation and amortization, using each hospital's reporting period.

[1] HCAI Hospital Annual Selected File, calendar year 2024 (April 2026 extract)

Payer mix

Medi-Cal was the second-largest source of net patient revenue, after commercial insurance.



Medi-Cal net patient revenue totaled \$44.30 billion. The expense column spreads each hospital’s costs across payers using HCAI’s allocation method. It shows how costs are distributed, not the cost of treating one more patient.

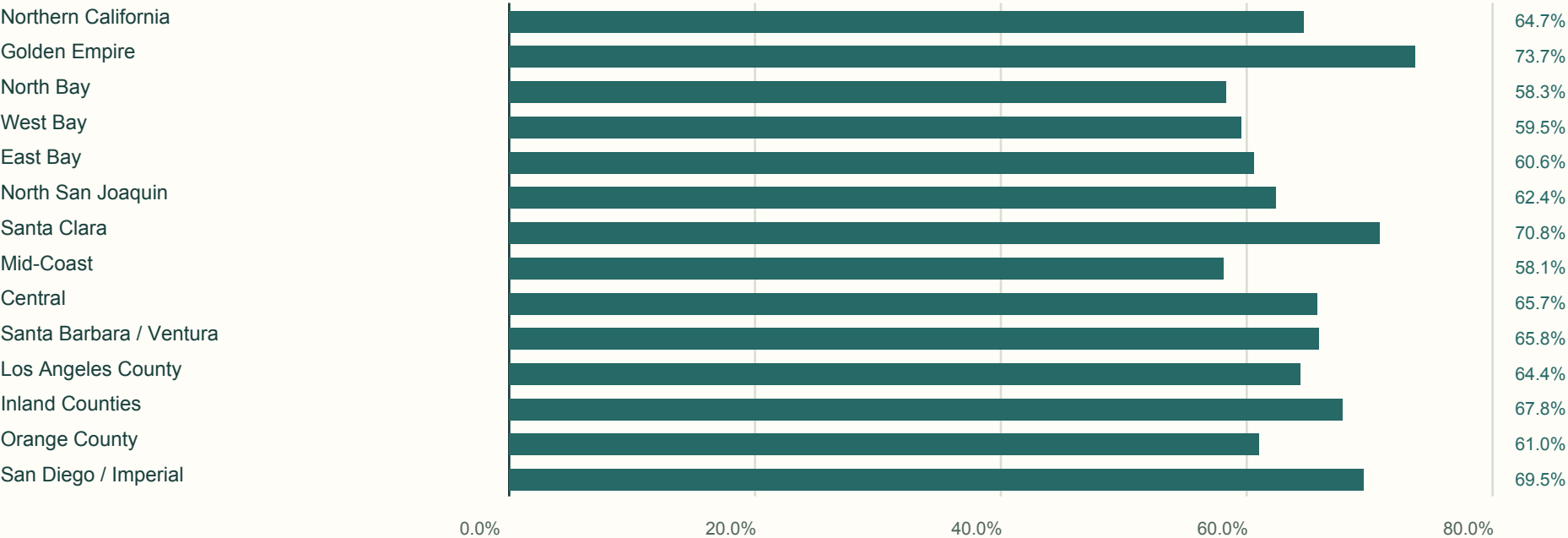
Notes: Net patient revenue is what hospitals expect to collect after contractual adjustments, so it is lower than gross charges. Charity care and bad debt are reported as charges and are not shown here as costs.

[1] HCAI Hospital Annual Selected File, calendar year 2024 (April 2026 extract)

Regional occupancy and operating margin

Occupancy ranged from 58.1% to 73.7% across regions, and operating margin from -7.2% to 6.7%.

Occupancy



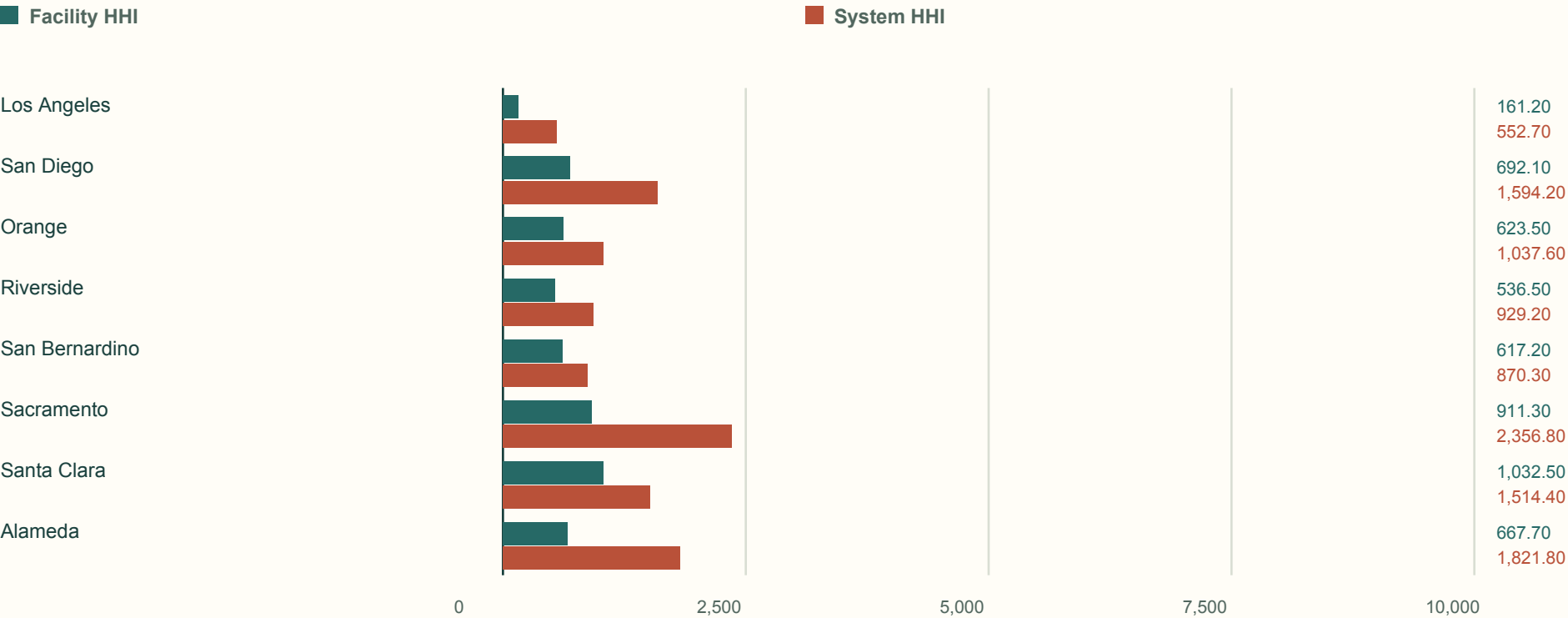
East Bay had the lowest operating margin and Golden Empire the highest occupancy. High occupancy can mean strong demand or too few beds. Regional averages are a starting point; check services and reporting-period flags before comparing individual hospitals.

Notes: Regions are the 14 HCAI Health Service Areas, based on hospital location. The market page (page 11) uses patient county of residence instead.

[1] HCAI Hospital Annual Selected File, calendar year 2024 (April 2026 extract)

Hospital market concentration by county

Grouping hospitals by health system raises measured concentration in every county.



Eight largest counties by resident inpatient volume; all 58 retained in workbook and data.

The 2024 patient-origin data count 3,661,942 inpatient discharges by patient county of residence. Documented health system links cover 89.3% of them. Hospitals without a documented system link are counted separately, which can understate concentration.

Notes: Herfindahl-Hirschman Index (HHI), 0 to 10,000, from 2024 inpatient discharges by patient county; includes hospitals outside the 299-hospital cohort. System links are from AHRQ's 2023 Compendium of U.S. Health Systems. A sensitivity test regroups 9 hospitals from four 2024 ownership changes (sources on page 16). HHI here does not define antitrust markets.

[1] HCAI Patient Origin and Market Share, 2024
[2] AHRQ Compendium of U.S. Health Systems, 2023 hospital linkage
[3] UCI Health–Tenet (four hospitals) ownership change, closed March 27, 2024

Study periods shown in table

Research on California hospital prices

Studies find wide price differences across California hospitals, but the most recent data are several years old.

Study and period	Finding	Boundary
Melnick GA, Fonkych K. Inquiry. 2016;53:0046958016651555. 2004-2013	Prices per admission increased 76% across all hospitals. Adjusted prices increased 113% at hospitals in the two largest systems versus 70% at other hospitals; by 2012-2013 the large-system differential was \$3,964 (25%).	One commercial payer, nominal prices, historical period, and observational design; the study does not establish that system membership alone caused the differential.
Zhuang T, Shapiro LM, Baker LC, Kamal RN. Clin Orthop Relat Res. 2023;481(6):1061-1068. March 2021 price files and 2021 CMS quality measures	Across 18 hospitals, the overall mean negotiated price was \$54,500 (SD \$23,200); payer-type means ranged from about \$20,300 for Medicaid to \$78,800 for commercial out-of-network coverage. No tested price-quality correlation met the study's corrected significance threshold.	Single system, one procedure, posted prices rather than claims-paid amounts, incomplete quality data, and cross-sectional associations.
Brodke DJ, Guo C, Aouad M, Brown TT, Bozic KJ. J Bone Joint Surg Am. 2019;101(24):2212-2218. 2009-2013; reference pricing began January 2011	Reference pricing was associated with a 19-percentage-point increase in lower-priced hospital selection and a \$5,067 reduction in mean insurer payment, while mean patient out-of-pocket payment increased \$1,991; most measured quality indicators did not change significantly.	Employer PPO population, elective joint replacement, observational parallel-trends design, and policy effects are not a statewide hospital price level.
Robinson JC, Brown TT, Whaley C, Finlayson E. JAMA Intern Med. 2015;175(11):1783-1789. 2009-2013; reference payment began January 2012	Reference payment increased use of low-priced facilities by 17.6 percentage points and reduced adjusted price by 21.0%; CalPERS reported \$7.0 million (28%) lower spending over two years, with no statistically significant complication change.	Includes hospital and nonhospital sites, one purchaser and carrier, outpatient procedure only, and observational policy evaluation.
Farrell KS, Finocchio LJ, Trivedi AN, Mehrotra A. J Gen Intern Med. 2010;25(2):110-114. Post-AB 1045 field experiment published 2010	Only 28% of hospitals responded. Estimates varied from \$3,500-\$65,300 for hysterectomy, \$2,700-\$36,000 for cholecystectomy, and \$350-\$5,805 for colonoscopy; 75% of estimates exceeded the median California Medicare reimbursement.	Estimates were often non-comparable, sometimes excluded physician fees, and do not represent negotiated insurer prices or actual paid claims.

These peer-reviewed studies cover different payers, services and years, so their estimates should not be combined. OHCA’s revenue per adjusted unit, shown elsewhere in the workbook, measures payment levels rather than negotiated prices.

Notes: Five peer-reviewed California studies. A focused search on September 26, 2026 screened 21 newer candidates and found no qualifying California hospital price study. RAND's next hospital price report is expected in 2027. Search decisions are in pricing_search_update.json.

[1] Melnick GA, Fonkych K. Inquiry. 2016;53:0046958016651555.
[2] Zhuang T, Shapiro LM, Baker LC, Kamal RN. Clin Orthop Relat Res. 2023;481(6):1061-1068.
[3] Brodke DJ, Guo C, Aouad M, Brown TT, Bozic KJ. J Bone Joint Surg Am. 2019;101(24):2212-2218.
[4] Robinson JC, Brown TT, Whaley C, Finlayson E. JAMA Intern Med. 2015;175(11):1783-1789.
[5] Farrell KS, Finocchio LJ, Trivedi AN, Mehrotra A. J Gen Intern Med. 2010;25(2):110-114.

Inpatient mortality ratings

For every condition, most rated hospitals performed as expected.

Condition	Better	As expected	Worse	Unrated
AMI	9	202	10	44
Acute Stroke	18	200	21	26
Carotid Endarterectomy	0	122	1	142
GI Hemorrhage	7	224	8	26
Heart Failure	18	233	10	4
Hip Fracture	3	219	6	37
PCI	7	126	6	126
Pancreatic Resection	0	68	2	195
Pneumonia	33	205	24	3

HCAI rates each hospital’s risk-adjusted mortality for specific conditions as better than expected, as expected or worse than expected. A hospital can be rated for several conditions, so the rows count ratings, not hospitals. A missing rating says nothing about performance.

Notes: 2024 HCAI Inpatient Mortality Indicators, linked by facility ID. 265 of 299 hospitals have at least one rating. The number of rated hospitals varies by condition. No combined score or ranking is calculated.

[1] HCAI Inpatient Mortality Indicators, 2024 hospital-condition observations

Quality: California and the United States

California did better than the U.S. on sepsis care and worse on ED time, patient recommendation and star ratings.

Measure	California	United States	Hospital n, CA / US	Unit and period
CMS hospital overall rating	3.06	3.16	257 / 2663	stars; August 2026 release
Patients who definitely recommend the hospital	67.76%	69.01%	262 / 2904	percent; 10/01/2024–09/30/2025
Appropriate care for severe sepsis and septic shock	68.76%	63.59%	260 / 2750	percent; 10/01/2024–09/30/2025
ED median minutes before leaving, excluding transfers and psychiatric/mental-health patients	183	170	225 / 2797	minutes; 10/01/2024–09/30/2025

Compared with all U.S. acute care hospitals reporting to CMS, California hospitals had a higher average sepsis care score, a lower share of patients who would definitely recommend the hospital, a longer median ED stay and a lower average star rating. No test of statistical significance was applied.

Notes: Both columns use the same CMS measures, periods and eligibility rules. Values are unweighted hospital averages, except ED time, which is the median of hospital medians. U.S. figures include California. The ED measure excludes transfers and psychiatric patients.

[1] CMS Hospital General Information, HCAHPS and Timely and Effective Care, August 2026 snapshots

National context

National figures show scale but cover a broader set of hospitals than the California cohort.

Measure	California	United States	Comparability
Staffed beds per reporting hospital	156.61	151.40	aligned concept; different hospital populations; beds per hospital
Annual inpatient admissions or discharges per hospital	9,283.31	6,552.18	contextual only; events per hospital
Nonprofit hospital share	56.9%	58.3%	aligned ownership grouping; different hospital populations; share of hospitals
Investor-owned hospital share	26.4%	23.9%	aligned ownership grouping; different hospital populations; share of hospitals
State or local public hospital share	16.7%	17.8%	aligned ownership grouping; different hospital populations; share of hospitals
Hospitals linked to a health system	76.3%	69.7%	contextual only; share of hospitals
2023-2024 hospital spending or operating-revenue growth	0.08	0.09	contextual only; annual percent change

The American Hospital Association (AHA) counts all community hospitals, a broader group than California’s 299 comparable general acute hospitals. National health spending measures payments by all payers, while the California figures measure hospital revenue. The gap between them is not a measure of price or efficiency.

Notes: 2024 AHA Fast Facts and CMS National Health Expenditure data. Definitions and limitations for each row are in national_hospital_benchmarks.csv.

[1] HCAI Hospital Annual Selected File, calendar year 2024 (April 2026 extract)

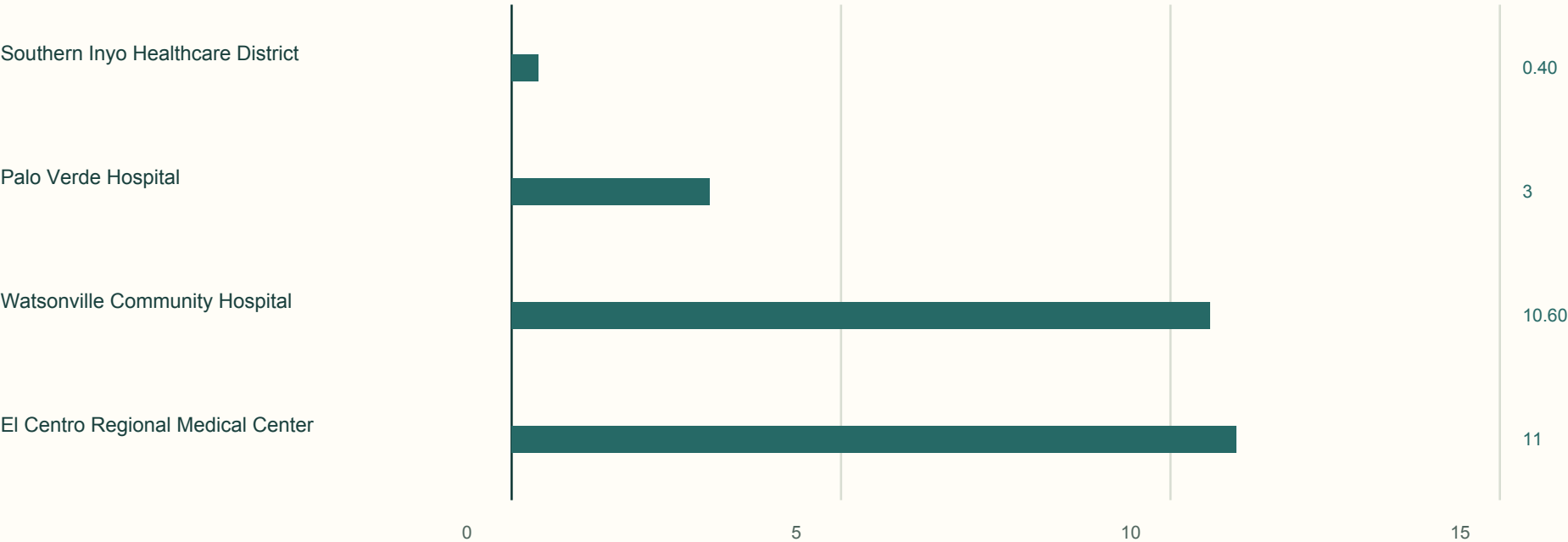
[2] AHA Fast Facts on U.S. Hospitals, 2026 (2024 survey)

[3] CMS National Health Expenditure Accounts, 2024

State support for distressed hospitals

State programs have directed loans and grants to financially distressed hospitals.

USD millions



HCAI awarded 4 small grants totaling \$25 million in 2026 and 16 distressed hospital loans totaling \$292.5 million in 2023 and 2024. Award amounts do not show what has been paid, forgiven or still owed, and loans must be repaid.

Notes: HCAI award lists, rechecked September 26, 2026; no new awards. The four 2024 hospital ownership changes cited below are tested on page 11.

[1] HCAI Distressed Hospital Funding Programs, rechecked September 26, 2026

[2] UCI Health–Tenet (four hospitals) ownership change, closed March 27, 2024

[3] UCLA Health–West Hills ownership change, closed March 28, 2024

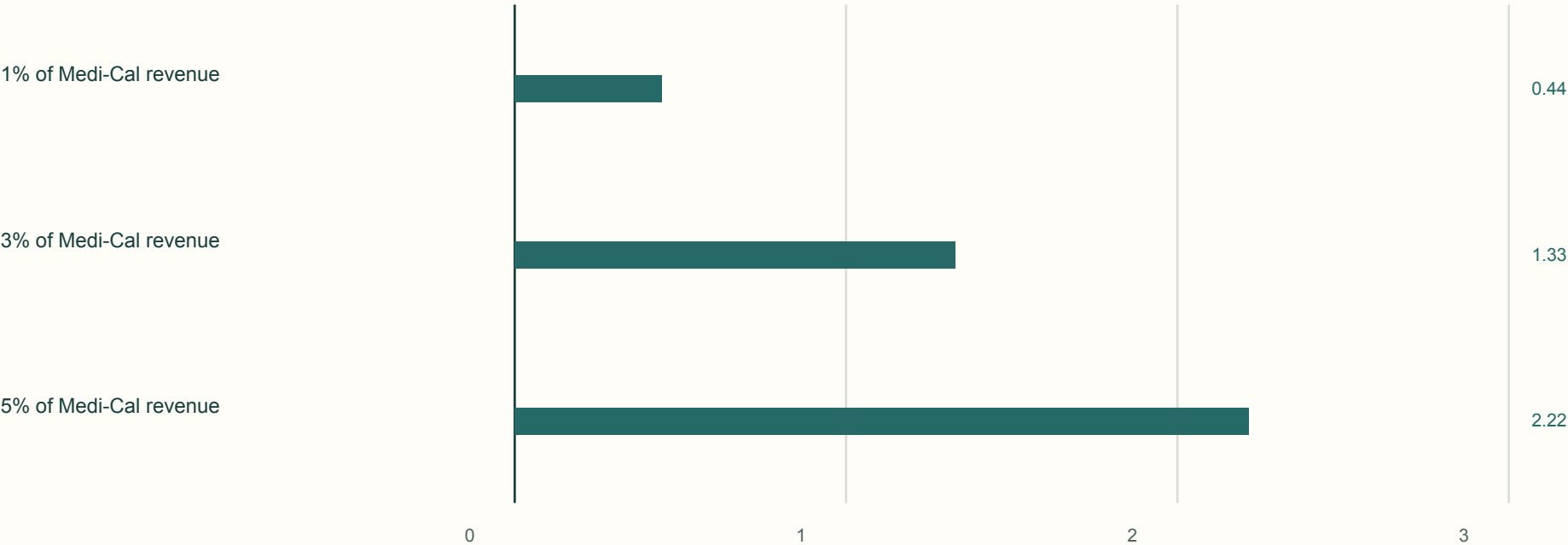
[4] UCSF Health–Saint Francis and St. Mary’s ownership change, closed August 1, 2024

[5] Rady Children’s–CHOC merger ownership change, closed December 31, 2024

Federal policy and Medi-Cal financing

Federal law limits two sources of Medi-Cal hospital financing, and the implementing rules are still being written.

USD billions



P.L. 119-21 limits provider taxes and state directed payments. California’s current managed care organization (MCO) tax ends December 31, 2026, and SB 125 creates a replacement from 2027 if CMS approves it. CMS rules on directed payments and provider taxes, issued in May and July 2026, are still proposed.

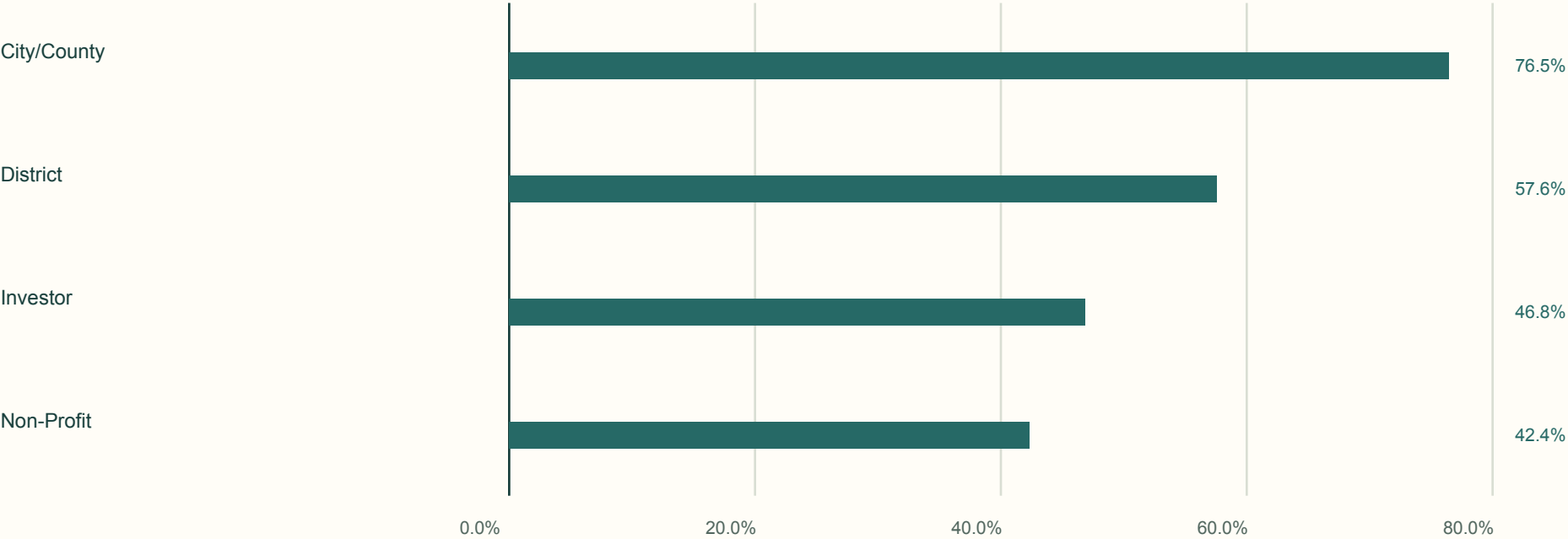
Notes: DHCS guidance and the Federal Register were checked on September 26, 2026. The chart shows what a 1%, 3% or 5% cut to 2024 Medi-Cal net patient revenue would equal. These are illustrations, not estimates of actual losses. The hospital quality assurance fee and the MCO tax are separate programs.

[1] HCAI Hospital Annual Selected File, calendar year 2024 (April 2026 extract)
[2] DHCS Medi-Cal Financing and Federal Register rule status, rechecked September 26, 2026

Hospitals with operating losses

Of the 299 hospitals, 141 lost money on operations in 2024.

Operating loss share



Hospitals with operating losses hold 44.8% of licensed beds and handled 41.9% of ED visits. One year of operating losses does not by itself mean a hospital is insolvent or likely to close.

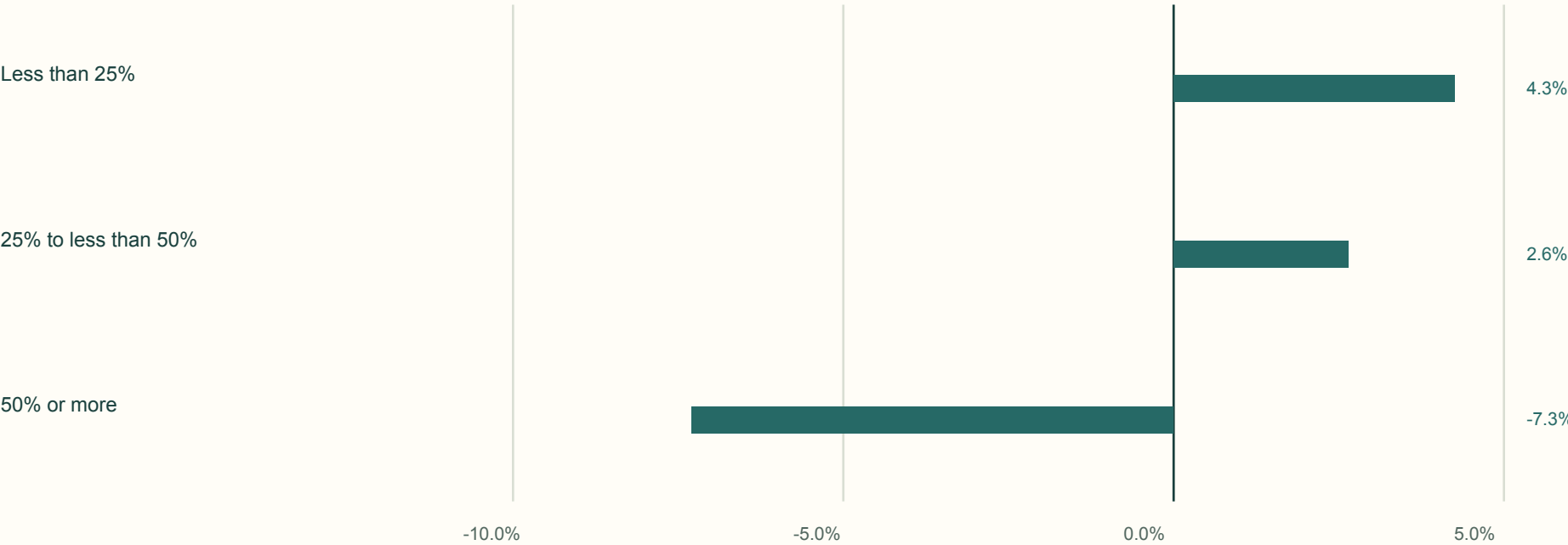
Notes: An operating loss means net from operations was below zero. ED visits are all-payer visits, not unique patients. The seven hospitals with nonstandard reporting periods are included.

[1] HCAI Hospital Annual Selected File, calendar year 2024 (April 2026 extract)

Hospitals by Medi-Cal revenue share

Hospitals that depend most on Medi-Cal had the weakest operating results.

Operating margin



The 61 hospitals that received at least half of their net patient revenue from Medi-Cal had a -7.3% operating margin and a 5.5% net income margin. Of these, 39 had operating losses and 21 had net losses. Nonoperating revenue closed much of the gap.

Notes: Groups are based on Medi-Cal fee-for-service and managed care net patient revenue as a share of all net patient revenue. The cutoffs were chosen for this analysis and are not a legal safety-net definition. Margins use summed dollars. The groups show an association, not a cause.

[1] HCAI Hospital Annual Selected File, calendar year 2024 (April 2026 extract)

Methods and reporting-period sensitivity

Excluding the seven hospitals with nonstandard reporting periods barely changes the results.

Cohort	Hospitals	Occupancy	Operating margin	Cost per adjusted discharge
All comparable hospitals	299	65.0%	1.7%	\$29,734
Standard reporting periods only	292	65.3%	1.9%	\$29,703

The analysis includes all 299 hospitals. This table repeats three measures without the seven whose 2024 reports cover unusual periods: operating margin moves from 1.7% to 1.9%. Self-reported data, source revisions and gaps in quality data limit every page.

Notes: HCAI 2024 selected file: 438 facilities and 247 fields. The cohort is 299 comparable general acute hospitals after removing six duplicate or partial-period rows. Trends use each year's cohort. All sources are public.

[1] HCAI Hospital Annual Selected File, calendar year 2024 (April 2026 extract)
[2] HCAI Hospital Annual Selected Files, 2012–2024; each year's comparable GAC cohort