

NATIONAL TREATMENT CENTER STUDY

COMPARISON REPORT (NO. 6)

RESULTS FROM THE FIRST THREE WAVES OF ON-SITE DATA COLLECTION, 1995-2001

A report detailing the findings from the first three waves of on-site interviews with a nationally representative sample of private alcohol and drug-problem treatment programs participating in the National Treatment Center Study conducted by the University of Georgia and the Georgia Institute of Technology.

July 2003

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I. Introduction

In 1994, the Institute for Behavioral Research at the University of Georgia and the Dupree College of Management at Georgia Institute of Technology launched a major national study of private substance abuse treatment centers. Funded initially by the National Institute of Alcohol Abuse and Alcoholism and later by the National Institute on Drug Abuse, this study was developed in response to the critical shortage of research in this area. Since 1994, three on-site data collections have been conducted with participating programs (1995-96, 1997-98, and 2000-01). A fourth on-site data collection is currently in progress and should be completed by November 2003.

Utilizing data collected during the first three on-site data collections, this report examines changes taking place within the private substance abuse treatment field during the period 1995-2001. During this study period, more than 100 of the 450 centers that participated in the initial 1995-96 data collection have closed and several others have been unable to continue their participation for different reasons. Nevertheless, 303 of the centers included in the 2000-01 data are centers that have been participating in this study since its inception. During both the 1997-98 and 2000-01 data collections, centers were added to the study using random sampling methods in order to maintain an adequate sample size while simultaneously ensuring the continued representativeness of this sample. Thus, it is important to note that the data presented in this report do not reflect changes taking place within a panel of centers over time, but rather changes taking place within the substance abuse treatment field. The sample of 400 centers that we maintain from data collection to data collection has been and continues to be representative of the nation's private substance abuse treatment system. As an example, if our findings show a significant decrease in the percentage of centers offering inpatient substance abuse treatment it does not necessarily mean that all of that change is the result of centers discontinuing their inpatient programs. Rather, the centers being added to the study over time may be much less likely to offer inpatient treatment, thereby reducing the overall percentage.

We hope that you find this report useful and informative. If you have questions about the report or about the National Treatment Center Study more generally, please do not hesitate to contact us at (800) 742-0694 or via e-mail at NTCS@uga.edu.

II. Key Trends Over Time

After comparing these three data collection periods, we detected several trends:

Closures: By the third data collection, over 23% of the centers that had participated in the first two data collections had closed. While the majority of the closures between 1995-96 and 1997-98 had occurred within not-for-profit hospital based centers [46.4%], the majority of the closures between 1997-98 and 2000-01 were reported within for-profit hospital based centers [46.2%].

Human Resource Management: The ratio of total employees to full-time equivalents rose over time, suggesting an increasing reliance on part-time employees. Additionally, the percentage of counselors who held a master's degree or higher increased from 47% during 1995-96 to 54% by 2000-01.

Clinical Programs: The percentage of centers offering inpatient detox, outpatient detox, and partial hospitalization decreased significantly from 1995-96 to 2000-01. Conversely, the percentage of centers offering DUI assessment, gambling addiction treatment, and methadone maintenance increased steadily between each data collection. Finally, many centers appear to be creating specialized treatment for specific demographic groups. Between 1995-96 and 1997-98, a significantly larger percentage of centers began offering treatment tracks for relapsers, adolescents and non-Hispanic minorities. By 2000-01, the percentage of centers offering specialized treatment to women, foreign language speakers, and HIV/AIDS clients had increased significantly.

Patient Data: The primary sources of referrals have shifted during the past two data collections. [This information was not collected at the first time point.] Referrals from the legal system, hospital/treatment system, social service agencies, and schools were more prevalent during 2000-01 than 1997-98. EAP referrals declined slightly over this time period. Data regarding the average percentage of occupied slots by level of care and the number of beds/slots were collected at each time point. Both the average number of available inpatient beds and the average percentage of those beds that were occupied on an annual basis increased significantly between 1995-96 and 1997-98. Conversely, between 1997-98 and 2000-01, the average number of outpatient slots per center increased while the average percentage of occupied slots showed a significant decrease. While this may seem to suggest that centers are increasing the number of outpatient slots, these trends more likely reflect the effect of higher rates of center closure among those centers with fewer numbers of outpatient slots. Thus, the average center in 2001 has a larger number of outpatient slots than did the average center in 1995.

Financial Information: At each data collection, administrators were asked the percentage of clients covered by different reimbursement sources. We found two primary changes over time. First, far fewer centers accepted Medicare during 2000-01 than during 1997-98 [60% vs. 73%, respectively]. Second, the percentage of self-paying clients increased significantly from 1995-96 to 2000-01 [11% vs. 20%, respectively]. These findings may partly be a function of our sample replacement strategy, wherein for-profit, nonhospital based centers comprise a greater proportion of the replacement centers, but they more likely reflect a recognition by center administrators of the need to decrease their center's reliance on managed care reimbursement.

III. General Center Information

A) Center Type

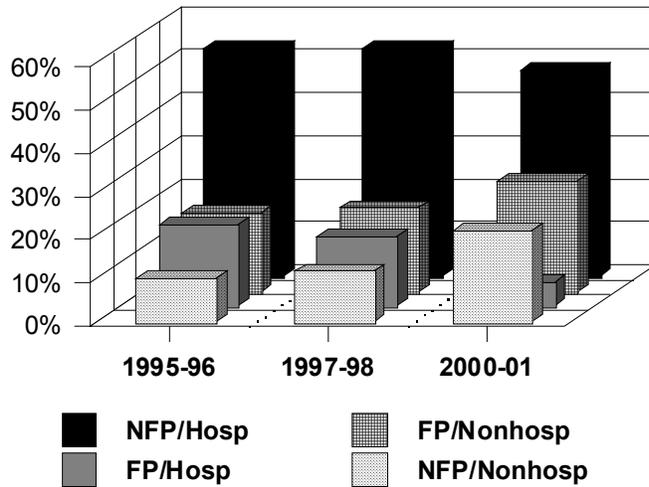
At each data collection, we asked respondents to tell us the status of their center: Is it hospital based or freestanding? Is it for-profit or not-for profit? During 1995-96, 62% of the centers were not-for-profit, and 72% were hospital based. By the 1997-98 data collection, the percentage of not-for-profit centers had increased to 64%, while the percentage of hospital based centers had decreased to 69%. These trends continued into 2000-01, with 69% of the centers declaring not-for-profit status, and only 53% based in hospitals. The decline in the percentage of centers based in a hospital from 1997-98 to 2000-01 was significant.

Based on the chart below, it is apparent that since 1995-96 a significantly greater percentage of centers are not-for-profit, nonhospital based centers, while significantly fewer centers are for-profit, hospital based. During 1995-96, only 10% of centers were not-for-profit, nonhospital based, while by 2000-01, over 21% of the centers were in this category. Conversely, during 1995-96, over 19% of centers stated that they were for-profit and hospital based; by 2000-01, this percentage had dropped to under 6%.

Replacement Strategy:

Twenty-six of the 400 centers surveyed in the second data collection did not participate in the 1995-96 portion of our study, but were recruited at the beginning of the second data collection to ensure a comparable sample size. Of these 26 centers, 81% were for-profit and 88.5% were freestanding. A significant proportion [76.9%] were for-profit, nonhospital based. This replacement trend continued into the third data collection, with 61% of the new centers being for-profit, nonhospital based. Thus, much of this shift is not reflective of centers moving out of hospitals in order to become freestanding, but instead reflects the adding of new centers to the sample.

Hospital and Profit Status Changes Over Time



B) Reported Closures

Since the beginning of our study in 1995, we have been tracking participating centers to determine which ones have closed since the time of our last contact. By the end of the 1997-98 data collection, 71 of the 450 centers [15.8%] that had participated in the initial on-site interview had closed. Of the 71 closures, 46.4% were not-for-profit hospital based centers, 27.5% were for-profit hospital based centers, 21.7% were for-profit nonhospital based centers, and only 4.3% were not-for-profit nonhospital based centers.

The third data collection [2000-2001] revealed that an additional 40 centers had closed, for a total of 111 out of 476, or 23.1% of all of those interviewed in the first three time points. While the majority of the closures between the first and second data collections had occurred within not-for-profit hospital based centers, the majority of closures between the second and third data collections were reported within for-profit hospital based centers [46.2%]. Between 1997-98, not-for-profit hospital based centers closures accounted for 30.8% of the total closures; for-profit nonhospital based, 15.4%; and not-for-profit nonhospital based, 7.7%.

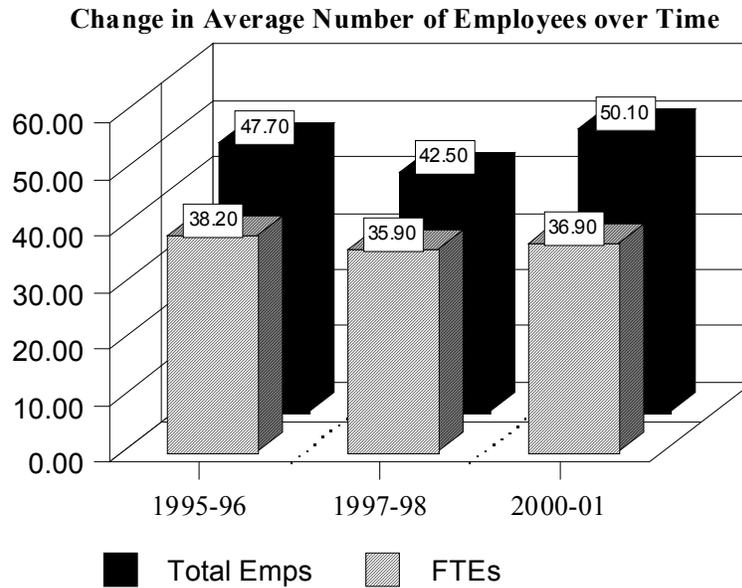
C) Accreditation Status

Two of the primary forms of center accreditation are JCAHO and CARF; hospital-based centers were significantly more likely to pursue JCAHO accreditation than their nonhospital based counterparts, while not-for-profit nonhospital based centers were more likely to receive CARF accreditation. Because JCAHO accreditation requires more time and greater expense, nonhospital based centers may prefer CARF accreditation. During 1995-96, about 90% of the centers interviewed had received JCAHO accreditation, while just under 2% had received the CARF equivalent. By 1997-98, the percentage of centers receiving JCAHO had significantly decreased to 82%, while the percentage receiving CARF had increased to 3.6%. This trend continued into 2000-01, with 73% of the centers reporting JCAHO accreditation, and just over 10% receiving CARF accreditation.

IV. Human Resource Management

A) FTEs and Total Employees

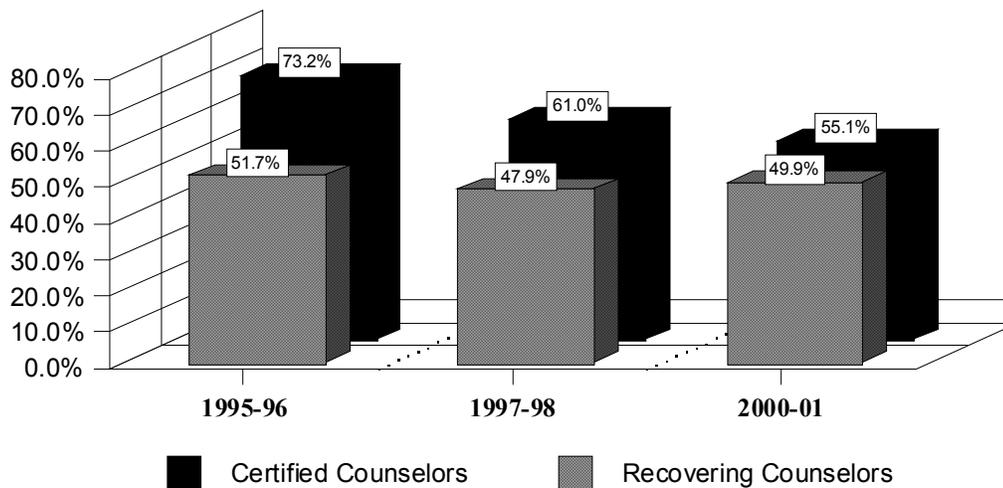
During 1995-96, the average center employed about 48 total employees and 38 full-time equivalents [FTEs]. By the second data collection, both numbers had declined, with centers employing an average of 42.5 total employees and about 36 FTEs. Our 2000-01 data indicate that centers have an average of 50 total employees and about 37 FTEs. The higher ratio of total employees to FTEs suggests that substance abuse treatment centers may be relying more heavily on part-time employees.



B) Counselors

Participants in the study's first data collection [1995-96] reported an average of 10.4 counselors on staff, with slightly more than half in recovery themselves and nearly three-fourths carrying some form of certification. During 1997-98, each center employed an average of 10.6 counselors, of which just under half were recovering and 61% were licensed or certified. During the third data collection [2000-01], participating centers reported an average of 13 counselors on staff. About 45% of these counselors were in recovery and 55% were licensed or certified. The declining trends in both recovering counselors and certified counselors accompanied by the increasing percentage of master's level counselors is indicative of the professionalization of the field.

Average Percentage of Recovering and Certified Counselors



C) Level of Education of Counselors

Administrators at each center were asked to report the percentage of counselors who had achieved specific levels of education, ranging from less than a bachelor's degree to an M.D. During 1995-96, nearly half of all counselors -- about 47% -- held a master's degree or higher. The percentage of counselors with a graduate degree increased to 49% by 1997-98. This trend continued through the 2000-01 data collection, with over half [54.0%] of all counselors holding at least a master's degree. Again, these results were expected and are indicative of the overall professionalization of the substance abuse treatment field.

D) Counselor Salaries

At each data collection, administrators were asked to report the range of counselor salaries as well as the average counselors' salaries for their respective centers. Between 1995-96, the average salary for all counselors was \$29,767, with a range of \$9,000 to \$80,000. Respondents in the 1997-98 data collection reported salaries ranging from \$7,890 to \$88,000, with an average salary of \$31,024. By 2000-01, the average salary for all counselors was \$34,126; the lower end of the range was \$5,200, while the upper range extended to \$95,000. It should be noted that some of the lower range salaries may reflect wages for part-time counselors. Overall, counselor salaries increased from \$29,767 in 1995 to \$34,126 in 2001, an average annual salary increase of approximately 2%.

E) Counselor Turnover

To determine the counselor turnover within a center, we asked the administrator to report the number of counselors who voluntarily quit over the past year and divided by the total number of counselors. Compared to other occupations, substance abuse treatment counselors have a very high turnover rate, exceeding those of even teachers and nurses, two occupations that have traditionally exhibited extremely high turnover rates. Although the average turnover rate of counselors is high, it does not vary significantly over time. The average annual turnover rate in 1995-96 was 17.4%; during 1997-98, it was 16.4%; and between 2000-01, it increased to 18.5%.

F) Employee Assistance Programs

In addition to other benefits, most of the centers in our study have offered Employee Assistance Programs [EAP] across at each time point. During 1995-96, nearly three-fourths [74%] of the centers had an EAP available for their employees; of these, 50.9% of the EAPs operated internally. The figures during 1997-98 were similar, with 74% of the centers offering EAPs. Again, just under half [47.5%] of the EAPs were in-house. By 2000-01, the percentage of centers reporting EAPs had dropped slightly to just under 70%, with 52.9% of those reporting internal programs.

V. Clinical Programs

A) Chemical Dependency Treatment Services

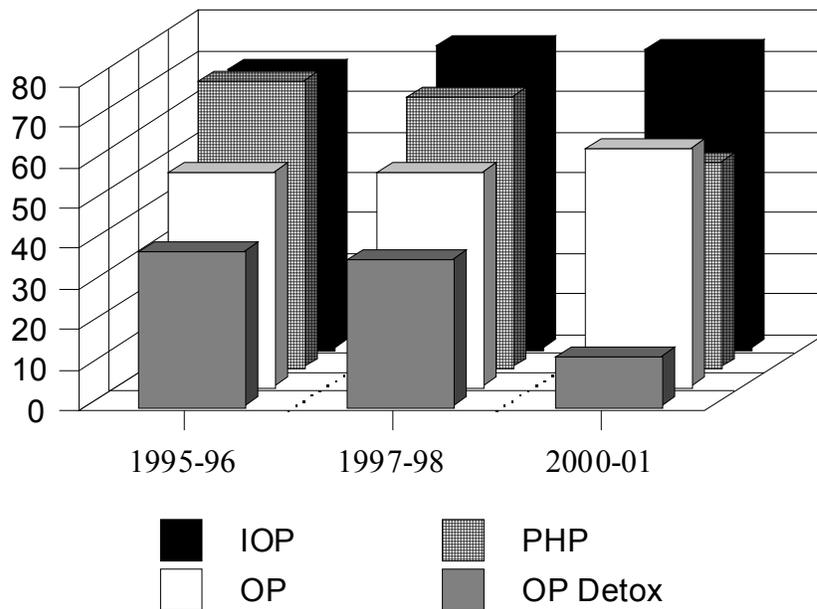
During each on-site visit, we asked respondents if they offered specific types of inpatient and outpatient treatments. Outpatient [<9 hours/week], intensive outpatient [9-20 hours/week], partial hospitalization [at least 20 hours/week], and inpatient detox were the most commonly offered levels of care for substance abuse treatment. The percentage of centers offering these levels of care is represented in the charts below.

Outpatient Programming:

The percentage of centers that offered intensive outpatient and outpatient programs was relatively stable over time. In general, about three-fourths of the centers offered intensive outpatient treatment, while about 55% offered treatment at the outpatient level.

The percentage of centers offering partial hospitalization dropped significantly between 1995-96 and 2000-01. During 1995-96, about 71% of centers offered this level of care. During 1997-98, this percentage had decreased to 67%, and by 2000-01, only 51% of the centers reported offering partial hospitalization as part of their treatment services. A similar trend appeared when examining outpatient detox. Outpatient detox was offered in 38% of centers during 1995-96, 36% of centers during 1997-98, and only 12% of centers during 2000-01.

Change in Outpatient Programming over Time



Outpatient Programming cont.

The decrease in centers offering partial hospitalization likely reflects centers' efforts to move away from levels of care that are underutilized. Generally speaking, managed care is more likely to admit a client for intensive outpatient treatment rather than partial hospitalization. For that reason intensive outpatient remains the most commonly offered type of outpatient treatment while partial hospitalization programs have become less prevalent.

By contrast, the decreasing percentage of centers offering outpatient detox likely reflects the end of a fad. A relatively sizeable percentage of centers adopted outpatient detox during the mid-90's, but have begun to phase those programs out after realizing that they were either ineffective or impractical.

Inpatient Programming:

The percentage of centers offering various levels of inpatient care also tended to decrease between 1995-96 and 2000-01. In particular, inpatient detox and inpatient adult chemical dependency programs showed sharp declines over this six-year period of data collection. During 1995-96, over 80% of the centers in our study included inpatient detox as a level of care; by 1997-98, this figure had declined to about 70%, and by 2000-01, it was only 56%. Similarly, inpatient adult chemical dependency programs were reported in almost 70% of centers during 1995-96, in about 65% of centers between 1997-98, and in just 43% of centers at the 2000-01 data collection. Inpatient adolescent chemical dependency programs, as well as inpatient psychiatric programs for both adults and adolescents peaked during the second data collection, then fell back to levels that approximated those during 1995-96. These percentages are shown in the graph below. [Note: Part of the decline may be reflective of the changes in our study's sample: only 13% of the centers that were added to the 2000-01 data collection offered inpatient care.]



B) Other Services

In addition to offering treatment for chemical dependency, many of the centers in our study provide a number of other behavioral health services. For example, an increasing number of centers have begun to offer treatment programs for gambling addiction and internet addiction. Furthermore, an increasing number of centers report DUI assessment as one of the services available to their clients. While about 44% of centers offered DUI assessment during 1995-96, this service was present in over 58% of the centers by 2000-01. Other types of treatment programs and the percentage of centers offering these services are shown in the table below.

Change in Percentage of Centers Offering Treatment Programs

<u>TREATMENT</u>	1995-96	1997-98	2000-01
Prescription drug addiction	96.6%	91.3%	93.7%
Dual diagnosis*	80.5%	91.1%	86.4%
Psychological problems	61.4%	64.0%	58.3%
DUI Assessment**	44.2%	51.0%	58.6%
DUI Program	18.1%	13.1%	13.3%
Codependency*	57.3%	47.8%	53.4%
Prison Program	6.4%	7.1%	8.2%
Nicotine addiction	N/A	N/A	42.2%
Eating disorders	30.0%	28.0%	29.6%
Gambling addiction*	14.7%	28.8%	34.4%
Internet addiction	N/A	N/A	10.8%

*The percentage of centers offering this type of treatment changed significantly between 1995-96 and 1997-98.

**The percentage of centers offering this type of treatment increased significantly between all data collections.

C) Treatment Tracks

Since 1995, there has been an increase in the percentage of centers offering specialized treatment tracks for specific demographic groups. Consistent across all three data collections, the most common groups for whom separate treatment tracks existed were relapsers, adolescents and women. An increasing proportion of centers are also offering treatment tracks to meet the specific needs of impaired professionals; the percentage of centers offering specialized treatments for these individuals more than doubled from 1995-96 to 2000-01. The increased presence of non-English speaking populations has also motivated many centers to offer foreign language treatment tracks. During 1995-96, only 1% of the centers in our study offered specialized treatment to speakers of foreign languages, but by the 2000-01 data collection, a significantly greater percentage – 8% – had developed programs specifically for this group of typically Spanish-speaking individuals. The percentage of centers that offer specialized tracks for various other demographic groups are listed below.

Change in Percentage of Centers Offering Specialized Treatment Tracks

<u>SUBGROUP</u>	1995-96	1997-98	2000-01
Relapsers*	15%	26%	28%
Adolescents	23%	32%	28%
Women**	11%	14%	23%
Impaired Professionals	5%	7%	12%
Foreign Language**	1%	2%	8%
Pregnant Women	4%	4%	7%
HIV/AIDS	2%	2%	6%
Gays/Lesbians	2%	2%	5%
Nonhispanic Minorities*	2%	8%	4%

*The percentage of centers offering this type of treatment increased significantly between 1995-96 and 1997-98.

**The percentage of centers offering this type of treatment increased significantly between 1997-98 and 2000-01.

VI. Patient Data

A) Referral Sources

During the two most recent data collections, administrators and clinical directors were given a list and asked to provide the approximate percentage of referrals their center received from the sources listed below. The following table shows the results of these requests. In general, legal system and hospital system referrals significantly increased from the second to third data collections. Legal system referrals included those from the courts, police, or criminal justice officials. Referrals from these sources increased from 13% to nearly 23% from 1997-98 to 2000-01. Hospital system referrals came from emergency rooms, within the treatment system or from other treatment centers.

Social service agencies and schools were also more significantly represented as referral sources in the 2000-01 data collection. Referrals from community mental health center staff and other similar organizations were considered social service referrals. The percentage of referrals from these sources nearly doubled from 1997-98 to 2000-01, from about 9% to almost 16%. School referrals also showed a dramatic increase, rising from about 3% to almost 8% of the total referrals.

The percentage of self-referrals and referrals from program alumni, physicians, clergy, EAP and non-EAP workplace showed no significant changes from 1997-98 to 2000-01. [Note: Because multiple referrals are often listed, the percentages listed below may not add up to 100%.]

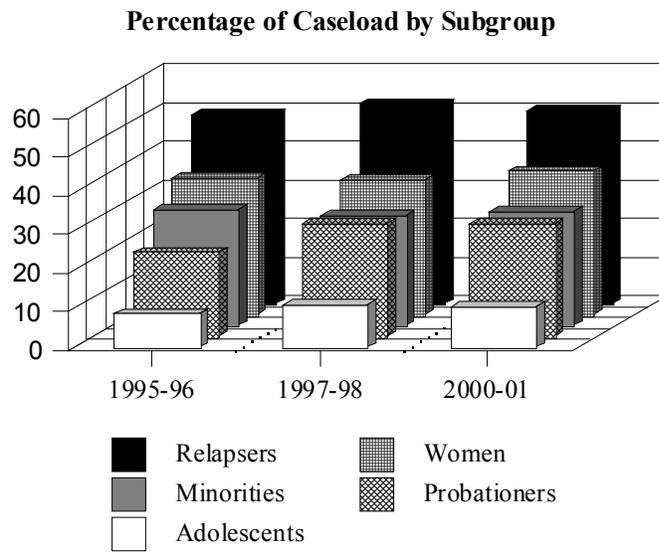
Change in Average Percentage of Referrals over Time

<u>Referral Source</u>	1997-98	2000-01
Self-referrals	22.9	23.0
Legal System *	13.0	22.9
Hospital/treatment system *	11.3	18.3
Social service agency *	8.7	15.5
Other health care provider	15.2	13.4
Program alumni	8.9	12.9
EAP	11.3	8.3
Physician	6.8	8.1
School *	3.1	7.8
Non-EAP workplace	NA	6.6
Clergy	1.2	2.6

* Represents a significantly larger share of the referral sources during 2000-01 than during 1997-98.

B) Patient Caseloads

In each data collection, respondents were asked to estimate the average percentage of their caseload represented by different population subgroups -- including women, minorities, relapsers, probationers, and adolescents. On average, respondents estimate that about half of the centers' clients are relapsers and just over 30% are minorities. Adolescents comprise, on average, about 10% of a center's caseload. There were no significant increases or decreases in these subgroups over time. The following table shows the average percentage of each group represented in the caseload.



C) Census

Respondents (both administrators and clinical directors) were asked to provide both current census and the 12-month average daily census for each level of care. The following table shows changes in the average daily census for each level of care over time.

Outpatient: Note that the average number of slots has increased over time; the addition of outpatient slots has shown a significant increase across each data collection, beginning with an average of 67 slots in 1995-96 and increasing to 93 by the 2000-01 data collection. The average percentage of occupied outpatient slots dropped significantly from 1997-98 to 2000-01. While an average of three-fourths of the slots were filled during 1997-98, only 63% of the slots were occupied during 2000-01. While it may appear that the number of slots in each center increased over time, this pattern is probably more reflective of the closing of smaller centers, leaving a proportionally greater number of larger centers in the sample.

Inpatient: For our survey, the average number of beds included adult and adolescent psychiatric care, adult and adolescent chemical dependency and inpatient detox: Some centers offered all five levels of care, while others may have offered only one. The number of inpatient care beds increased significantly from 1995-96 [40 beds] to 2000-01 [50 beds]. This increase in the number of inpatient beds is largely the function of a *decreasing* number of centers offering inpatient services; smaller inpatient programs have been dropped by many centers, leaving the larger programs to serve an increasing number of clients. This trend may also account for the increasing occupancy rates; many low occupancy programs have been dropped in favor of programs that are able to retain a larger number of clients. Thus, while the average occupancy rate was 59.0% during 1995-96, nearly 74.4% of the available beds were filled by 2000-01.

The average number and percentage of occupied slots for partial hospitalization and intensive outpatient did not show a significant increase or decrease over time. (Averages are based only on those programs offering a given level of care, not the entire sample.)

Average Percentage of Occupied Slots by Level of Care

<u>SUBGROUP</u>	1995-96	1997-98	2000-01
Inpatient Care [*] <i>Average number of beds</i> ^{**}	59.0% (40)	75.5% (44)	74.4% (50)
Partial Hospitalization <i>Average number of slots</i>	50.7% (19)	47.9% (20)	50.3% (20)
Intensive Outpatient <i>Average number of slots</i>	59.4% (27)	61.5% (33)	63.3% (34)
Outpatient ^{**} <i>Average number of slots</i> ^{***}	74.3% (67)	75.0% (74)	63.1% (93)

*The percentage changed significantly between 1995-96 and 1997-98.
 **The percentage increased significantly between 1997-98 and 2000-01.
 ***The percentage increased significantly across all time points.

D) Payor Mix

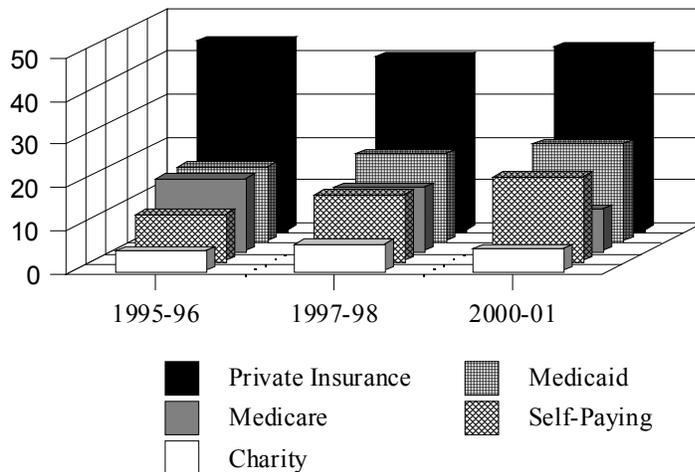
Administrators were asked to estimate the percentage of clients paying for services via the following methods: Medicaid, Medicare, private insurances, HMOs, PPOs, self-pay [100% out-of-pocket], and charity. In 1995-96, about 62% of centers treated Medicaid patients and 74% treated Medicare patients. By 1997-98, these percentages were 67% and 73%, respectively. The data from 2000-01 show about two-thirds of the centers accept Medicaid and about 60% accept Medicare, a significant drop from 1997-98.

In addition to the decrease in the percentage of centers accepting Medicare patients, there has also been a decrease, among centers accepting Medicare, in the average percentage of patients covered by Medicare. In 1995-96, about 17% of clients were covered by Medicare; by 2000-01, this had decreased to about 10%. By contrast, in 1995-96, about 17% of the clients were covered by Medicaid; by 2000-01, nearly 23% of clients were covered by Medicaid.

The percentage of self-paying clients also increased significantly from 1995-96 to 2000-01. In 1995-96, approximately 11% of the clients paid for services completely out-of-pocket. By 1997-98, this had risen to about 15%. In 2000-01, respondents reported that, on average, 20% of their clients were self-paying. This increase may be a function of our sample replacement strategy, wherein for-profit, nonhospital based centers comprise a significantly greater percentage of the replacement centers.

The percentage of clients using private insurance, including HMOs and PPOs, or charity remained stable over time.

Payor Mix



VII. Financial Data

A) Retail Charges

Administrators were asked to provide their daily “retail” charges for each of their levels of care. By retail charges, we mean rates that are not negotiated, discounted or contracted rates. The following table shows the average retail charges across all time points. In general, retail charges increased between each data collection; however, not all increases were significant and many may simply reflect normal inflation patterns.

Daily charges for all inpatient care increased from 1995-96 to 1997-98. In particular, charges for inpatient detox and inpatient adolescent CD increased significantly between these two time points. Between 1997-98 and 2000-01, however, inpatient adolescent CD charges *decreased*, while the charges for inpatient adult psychiatric care increased.

The average daily retail charges for partial hospitalization, intensive outpatient, and outpatient care showed only marginal increases across all data collections.

Change in Average Daily “Retail” Charges over Time			
<u>SUBGROUP</u>	1995-96	1997-98	2000-01
Inpatient Detox	\$584.85	\$652.23	\$665.13
Inpatient Adult CD	\$507.44	\$537.11	\$537.63
Inpatient Adolescent CD	\$591.59	\$681.13	\$624.44
Inpatient Adult Psych	\$720.22	\$740.55	\$797.04
Partial Hospitalization	\$265.19	\$275.67	\$293.16
Intensive Outpatient	\$136.36	\$133.85	\$156.85
Outpatient	\$69.21	\$70.23	\$85.34

B) Annual Operating Costs and Revenues

At each data collection, administrators were asked to provide approximate total revenues and expenditures for their respective centers for the most recent fiscal year. During 1995-96, about 81% of the centers reported that their revenues met or exceeded expenses. This number decreased to about 78% during 1997-98, and dropped to 76% by 2000-01. The following chart shows the average annual costs and revenues for each data collection. As illustrated in the chart, both the average revenues and the expenditures increased over time, although none of these increases are significant. On a positive note, the ratio of revenues to operating costs increased over the three data collections, suggesting greater financial stability within participating centers.

