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Medicare Transfer DRGs Improving Post Acute Discharges

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Executive Summary

Introduction

Senior Consulting, LLC ("SC") has completed numerous related studies and reports on Post-Acute discharges from Acute Hospitals and the long term care industry in California, where there is a depth and breadth of data that the Office of Statewide Health Planning and Development (OSHPD) provides for both hospitals and skilled nursing facilities. They are referenced in this Executive Summary, with many included with this complete Report. The Report has been completed from both an acute and skilled care perspective.

Over 400 hospitals nationwide randomly participated in Health Care Advisory Board ("HCAB") 2004-05 case studies on Post-Acute discharge strategies including Automated Post-Acute Placement, Fast-Tracking SNF Placement and establishing a SNF Care Improvement Team, with a Summary of HCAB Findings on Page Five of this Report.

Skilled Care Perspective

All nursing homes are looking for more Medicare patients to offset higher populations of Medi-Cal patients, which have typically inadequate reimbursement. They usually have available beds, at least for Medicare or Private patients, yet the majority of hospitals advise us they have difficulty discharging certain Medicare patients to SNFs, such as those with TPN, Ventilator, Complex Wounds, Tracheotomy, Psychiatric and/or Dialysis needs, among others. Some skilled care operators commit resources, such as third party strategic planning and implementation, sufficient management staff in census development, and case managers at the hospitals so as to capture a substantial percentage of Medicare discharges, but very few commit to all these important directives or provide tools to develop census from an acute perspective.

In most California markets, there are few, if any nursing homes that are appropriately staffed and trained for care of these patients; yet training SNF staff is in the best interest of both the local hospital and the SNF. In the service area of one hospital, its Medical Director, Senior Management and Discharge Planners all concurred that none of the SNFs among the 15 plus facilities in their primary and secondary service areas had an appropriately trained staff. In selected markets, there are SNFs in a position to care for these patients. In other markets, there are hospital-based Distinct Part Skilled Nursing facilities ("DP-SNF") and/or Subacute facilities for Medi-Cal patients in California that are well equipped for these Medicare patients that have excessively long stays in an acute setting. DP-SNF units present only a partial solution for Acute Hospitals, but most are small units that rarely address the overall need for higher acuity long term care patients.

Skilled care nursing facilities are the primary option for transfer discharges from a hospital. Many SNFs tell discharge planners they don't have available beds when complex Medicare or Medicaid patients are in need of a bed, but they always seem to have a bed for a Private Pay patient or Medicare rehabilitation patient. As referenced in Exhibit A, Statewide and Regional Variances for Occupancy and Payer Mix, a Senior Consulting report on statewide, regional and by type of ownership for skilled care facilities statewide, there are plenty of beds available.

In the majority of markets, hospitals have many nearby skilled nursing facilities, yet are obligated and typically provide patients and families with just three options. They choose the facilities where they respect the provided care and that make their job the easiest in lessening paperwork or accommodating the transfer. While SNFs deny a smaller percentage of the hospital's patients for admission, typically those are the patients that exceed the targeted LOS and contribute exponentially to negative margins. There are solutions such as financial modeling, training, education that can position the SNFs to accept many of these patients for their benefit as well as the referring hospital.

Acute Perspective

In October 1983, the Medicare Prospective Payment System ("PPS") was adopted by the federal government. Under PPS, hospitals are paid a predetermined fixed rate for each Medicare admission, regardless of the patient's Medicare Length of Stay ("LOS"). There are 559 DRG categories defined by the Centers for Medicare and Medicaid Services ("CMS", formerly known as HCFA), each category is "clinically coherent" or a similar clinical condition. For some DRGs, special rules were established for patients who are discharged immediately following their hospitalization to a rehabilitation hospital, SNF or home health care. These DRGs are what are referred to as "Transfer DRGs," a result of the "Balance Budget Act" of 1997. Initially, there were only 10 Transfer DRGs, which increased to 29 Transfer DRGs in FY 2004 before being expanded to 182 Transfer DRGs as of October 1, 2005. Further information of PPS and is contained in the section Background on PPS and Medicare Transfer DRGs beginning on Page Six of this Report.

SC completed an Analysis of CA OSHPD Data on Length of Stay ("LOS"), the summary of the Analysis begins on Page Eight of this Report, which includes a statewide analysis of LOS, a review of the overwhelming majority of California Counties, and a standalone analysis of over 50 individual hospitals. We found that the LOS in CA was higher than the national average, yet varied substantially by region throughout the State, as well as within Counties for acute hospitals. The results of the financial analysis were astounding, as many hospitals could save $500,000 or more, some well over $1,000,000 annually, if the Hospital could manage its discharges in line with national LOS averages or averages within many regions of the State.

SC completed an Analysis of Individual Patients, by LOS grouping for Medicare Transfer DRGs, attached as Exhibit B, from our review of a client's actual data, by patient and by DRG, with 34% of the patents in the sampling exceeding the targeted LOS by 20% or more. This hospital has an average of 104 occupied beds, and a **50% improvement in**

discharging only 17% of their Medicare patients with Post-Acute transfer DRGs would result in savings of over $1 million per year. Nonetheless, we found that only one out of four executives or managers at other hospitals had access to even a portion of the available data that resulted in this internal Analysis.

While there is substantial data available from OSHPD, including total annual discharges for all payer types, including Medicare for each hospital in the State and collectively, there is no data on the actual total number of Medicare Post-Acute Transfer Discharges. Senior Consulting analyzed three separate databases from OSHPD for DRGs that were available, which can be only be sorted by Top 25 in Number of Discharges, ALOS and Average Charge Per Stay, regardless of payer type. Since there is no data on the total volume of Medicare Post-Acute Transfer Discharges and limited available data on types of discharges, critical to understanding the need for expanded SNF and Acute synergies, SC then manually sorted these three separate databases to assess the majority of specific Medicare Post-Acute Transfer Discharge DRGs, by hospital and by regions.

Statewide, there are a total of 36 District or County hospitals of at least 100 beds, and another 29 hospitals of this type with 99 beds or less. Approximately 53% of the larger group of District/County hospitals also operates DP-SNF beds. For the 19 District/County Hospitals operating DP-SNFs, only 6 or 32% of the hospitals have SNF units with occupancy less than 80%. Nineteen of the 29 hospitals in this group with less than 99 beds have an average of only 31 acute beds, as there are many rural Districts.

Not including systems of 1,000 beds or five hospitals or more, there are a total of 60 Nonprofit hospitals of at least 100 beds, and another 11 hospitals with 99 beds or less. 55% of the larger group of Nonprofit hospitals also operates Long Term Care or SNF beds. Of the 33 Hospitals that operate SNFs, 19 or approximately 63% of the hospitals have SNF units with occupancy less than 80%. However, many of these units have a small number of beds, with a typical dual purpose to reduce LOS for certain acute patients and contribution margins on other types of patients such as those needing rehabilitation.

SC completed individual Analysis of Transfer DRGS utilizing the three groupings of Top 25 data available from OSHPD for over almost 100 hospitals and compared County, District and Nonprofit Hospitals as well as For Profit Hospitals. Three separate analyses were completed for Northern California, Southern California and Central Valley Transfer Discharges, as well as an analysis of For Profit Hospitals. These reports, attached as Exhibits C, D, E and F, include a Summary that projected Net Losses for the minority of patients that exceed LOS, as well as sections with the Number of Discharges, ALOS, Charges, and Frequency for each hospital and by grouping. In the section of this Report entitled Regional and Type of Ownership Transfer Discharge Analysis beginning on Page 17, we have provided summary analysis and conclusions on these variances. Finally, in the last section of this Report, Acute and SNF, Solutions for Mutual Benefits, beginning on Page 23, SC has provided potential solutions to improve discharges and contribution margins for acute hospitals.

Conclusions

In the comprehensive analysis of statewide 2004 data and analysis of recent client data for late 2005, before the number of Transfer DRGs increased from 29 to 182, hospitals were losing revenue because of slower discharges for a minority of their patients. With Transfer DRGs, let alone financial reporting of groupings of patients below and above the LOS, this lost revenue is not visible or quantifiable to management. Many of these patients are not clinically appropriate for discharge to a skilled care setting, since there is rarely a SNF in the hospital service area with staff trained in the care of many higher acuity patients, as well as management and vendor support such as Pharmacy. These facilities do not have clinical criteria for admissions of higher acuity Medicare patients comparable to a licensed Medi-Cal Subacute unit, another relationship with a SNF that could be established with service area analysis as part of expanded SNF/Acute synergies. Many SNFs are willing to improve their staff's skill sets, a critical need to meet the needs of the local hospital that can improve their own contribution margins, with staffing one of the few areas in which a hospital can provide direct or indirect assistance to SNFs.

The delicate balance of care and business exists at times for all operators, with the ongoing related conflicts between caregivers, nursing management, case managers and their counterparts in management, from operations to finance exacerbating discharge decisions.

With more Transfer DRGs to manage, hospitals cannot improve their ability to discharge patients without improved fiscal approaches and support, and a commitment to additional resources. Directives that can assist in accomplish these improvements include:

1) Complete an assessment of past practices, including suggestions of clinical criteria assuming a SNF with higher level nursing skills sets was available for discharge of complex Medicare patients

2) An analysis of the SNF market to establish the best options for patients in SNFs to establish appropriate care planning and staffing, and then,

3) Implementation of new protocols and procedures by an expanded discharge planning team.

Summary of Findings by the Health Care Advisory Board (HCAB)

Over 400 hospitals nationwide were randomly chosen and participated in HCAB case studies on post-acute discharge strategies including Automated Post-Acute Placement, Fast-Tracking SNF Placement and establishing a SNF Care Improvement Team. Post-Acute discharges included 47% to SNF, 33% to Home Health, 15% to LTCH, Rehabilitation and Psychiatric Hospitals and 5% to Hospice.

The discharge process is driving a higher Length of Stay, which included a separate case study of a six-hospital system where the average length of stay "LOS" for all patients in 2002 was 5.02 and average LOS for patients transferred to SNFs was 10.22 during the same time frame. The establishment of an e-Discharge Network with area SNFs reduced LOS in 2003, saving approximately $500,000 from LOS reductions in one year. Note that 76% of area SNFs participated in the Network.

In another case study, a seven-hospital system in the Midwest was constrained by limited SNF capacity in its service area, despite 88 transitional beds owned within the system. In establishing a SNF network, access to SNF beds more than tripled. Benefits to the hospital included the admission of patients 24/7, minimum of 6 days per week rehabilitation coverage, and acceptance and admittance of "hard to place" patients, with confirmed benefits to the SNFs included steady transfer volumes and good Payer Mix. A third case study over a period of 4 years showed a steady decline each year in Medicare LOS based on similar programs.

In one case study, after establishing a SNF network with an e-Discharge Network, the average time for discharges was reduced from 240-480 minutes to 15 minutes. **HCAB found that retention of a Network Manager** such as Senior Consulting to act as liaison, manage the SNF network, and conduct biannual network meetings, further enhanced the benefits and programs, including maintaining a reduced LOS and saving substantial time for the Social Work Department/Discharge Planning of the hospital.

Addressing physician reluctance to transfer was also found to be an issue in the overall study, with establishment of a SNF Care Improvement Team resulting in improved physician satisfaction, resulting in improved discharges to area SNFs. Within 18 months of adding staff positions to the SNF care improvement team, LOS was reduced by over 2.0 in one study. Overall, physician confidence in area SNFs improved from 34.6% to 68.2% within 3 years.

Background on PPS and Medicare Transfer DRGs

The Medicare Prospective Payment System (PPS) was introduced by the federal government in October 1983, as a way to change hospital behavior through financial incentives that encourage more cost-efficient management of medical care. Under PPS, hospitals are paid a pre-determined rate for each Medicare admission. Each patient is classified into a Diagnosis Related Group (DRG) on the basis of clinical information. Except for certain patients with exceptionally high costs (called outliers), the hospital is paid a flat rate for the DRG, regardless of the actual services provided. Each Medicare patient is classified into a Diagnosis Related Group (DRG) according to information from the Medical Record that appears on the bill:

- Principal Diagnosis (why the patient was admitted)
- Complications and Comorbidities (CCs - other secondary diagnoses)
- Surgical Procedures
- Age
- Gender
- Discharge Disposition (routine, transferred, or expired)

There are 559 DRG categories defined by the Centers for Medicare and Medicaid Services (CMS, formerly known as HCFA). Each category is designed to be "clinically coherent." In other words, all patients assigned to a DRG are deemed to have a similar clinical condition. The Prospective Payment System is based on paying the average cost for treating patients in the same DRG.

Each year CMS makes technical adjustments to the DRG classification system that incorporates new technologies such as laparoscopic procedures and refine its use as a payment methodology. CMS also initiates changes to the ICD-9-CM coding scheme. The DRG assignment process is computerized in a program called the Grouper that is used by hospitals and fiscal intermediaries.

Each year CMS also assigns a relative weight to each DRG. These weights indicate the relative costs for treating patients during the prior year. The national average charge for each DRG is compared to the overall average. This ratio is published annually in the Federal Register for each DRG. A DRG with a weight of 2.0000 means that charges were historically twice the average; a DRG with a weight of 0.5000 was half the average.

Transfer DRGs

For some DRGs, special rules have been created for patients who are discharged immediately following their hospitalization to a rehabilitation hospital, SNF or home health care. These DRGs are what are referred to as “Transfer DRGs,” an outgrowth of the “Balance Budget Act” of 1997. Initially, there were only 10 Transfer DRGs beginning in FY 1999. This was increased to 29 Transfer DRGs in FY 2004 before being expanded to 182 Transfer DRGs as of October 1, 2005. As per information provided by the Center for

Medicare and Medicaid Services ("CMS"), there are approximately 12 million Medicare discharges per year nationally, with about 52% being Transfer DRGs.

CMS has access to the inpatient datasets, which it acquires from the Medicare fiscal intermediaries. CMS and CMS contracted researchers identified several DRGs, which contained the highest percentage of patients transferred from an acute hospital to alternative sites for post-acute care. One example quoted by CMS was the need for most patients with a stroke to have rehabilitation in a long term care setting.

A hospital is financially penalized by CMS through Medicare for an "early transfer" of a patient classified in one of the Transfer DRGs. An early transfer patient is one who is discharged more than one day sooner than the geometric mean LOS ("GMLOS") of patients in that DRG. Hospitals are given financial incentives to minimize Medicare patient's LOS under the prospective payment system. However, early transfers actually increase costs, as Medicare was paying for care in both the acute and post-acute settings.

The reduction in payment to hospitals for early transfer follows a complicated formula, depending on the patients actual LOS and the GMLOS for that DRG. It is impossible for a hospital to increase Medicare revenues, the best they can do is minimize its reduction in payments. To avoid improperly billing for discharges, hospitals should pay particular attention to the CMS post-acute care transfer policy and keep an accurate list of all designated DRGs subject to that policy (OIG 2005, 13-14).

The per diem rate paid to a transferring hospital is calculated by dividing the full DRG payment by the geometric mean length of stay for the DRG. Based on an analysis that showed that the first day of hospitalization is the most expensive (60 FR 45804), the CMS policy provides for payment that is double the per diem amount of the first day (Section 412.4(f)(1)). The purpose of the IPPS transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital early in their stay in order to minimize costs while still receiving the full DRG payment. The transfer policy adjusts the payment to approximate the reduced costs of transfer cases. See 70 FR 23411 (May 4, 2005). Therefore, for both early transfers and patients that exceed the reimbursed LOS, the hospital has an incentive to discharge patients as soon as clinically appropriate in light of the Transfer Discharge Policy since the reimbursement is capped and expenses continue for as long as the patient remains at the hospital. Transfer cases are also eligible for outlier payments. The outlier threshold for transfer cases is equal to the fixed-loss outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the case, plus one day.

Again, hospitals are "penalized", or revenues are lessened, for the early transfer of a patient in a Transfer DRG. This is a complex calculation by CMS, applicable to 169 of the current 182 Transfer DRGs.

It has been estimated that the changes from FY 2004 Medicare to FY 2006 have reduced Medicare revenue by $10 million per hospital nationwide. Addressing early transfers, based on FY 2004 Medicare revenues of $10 million, projecting a 2% reduction would result in $200,000 savings to the hospital.

Analysis of CA OSHPD Data on Length of Stay ("LOS")

SC has conducted a review of Length Of Stay ("LOS") for all California Hospitals, as well as all Counties with four (4) or more Hospitals, which includes background and general relevance on all payor types.

Medicare – GMLOS & DRGs

Under the Medicare post-acute-care (PAC) transfer policy, acute-care hospitals are reimbursed under a per-diem formula whenever beneficiaries are discharged from selected diagnosis-related groups (DRGs) to a prospective payment system (PPS)-exempt hospital/unit, such as inpatient rehabilitation facility (IRF) or long term acute care (LTCH), skilled nursing facility, home health agency (services beginning within three days of discharge), or a prospective payment system (PPS)-excluded facility.

Total per-diem payments are below the full DRG payment only when the patient's length of stay (LOS) is short relative to the geometric mean LOS for the DRG; otherwise, the full DRG payment is received. The per-diem calculations result in a payment below the full DRG payment only if the inpatient stay is more than 1 day shorter than the geometric mean length of stay (GMLOS) for the DRG in that year; otherwise, the full DRG payment is received. Geometric Mean Length of Stay (GMLOS) is the statistically adjusted value for cases in a given DRG, excluding outliers, transfer cases, and negative outlier cases that would normally skew the data. This value is computed annually by the Centers for Medicare and Medicaid Services ("CMS"). GMLOS is used to determine payment to the hospital only when a PAC transfer is involved. In our calculations for LOS variances for individual hospitals, we use a GMLOS of 4.20, adjusted from fiscal year 2005, an average of the GMLOSs for all DRGs is 4.04. This average is not weighted for the number of patients assigned to a particular DRG.

The decision to discharge a patient from a hospital is a decision that should be made by the treating physician (in coordination with the case manager/social worker) and in conjunction with the patient and family members in order to accomplish what is in the best interest of the patient. However, the PAC Transfer Rule should be a consideration when facilitating clinically appropriate discharges. Historically, hospitals have become more focused on monitoring and reducing the hospital DRG length of stay (LOS). However, many times patients' needs can be appropriately met by staying in the hospital an additional day or two before transitioning to a post-acute provider. The key is that patients receive the care needed and move effectively and efficiently through the continuum of care.

Mental Health

In California, the State's 58 counties are responsible for public mental health services, including services for Medicaid-eligible. The counties are at risk for mental health services for their residents, and they control how mental health dollars are spent. When a county needs to place a resident in a State facility, it pays a predetermined per diem rate. Counties

use the State psychiatric hospitals only as a last resort, mostly to treat the hardest to serve, most chronically ill civil patients. This is due to the high cost of State facilities, their long distance from many communities, and the fact that the State hospitals primarily serve forensic patients. California's State psychiatric hospitals receive a small share of their operating budgets from Medicaid, with those Medicaid dollars generally intended for civilly committed patients 65 years and older and 21 years and younger, both noticeably small groups. (Source - Medicaid Financing of State and County Psychiatric Hospitals, Substance Abuse and Mental Health Services Administration's (SAMHSA) National Mental Health Information Center).

California's system of psychiatric health facilities (PHFs) (both publicly and privately owned), along with psychiatric units in general hospitals and freestanding psychiatric hospitals, serve local needs for acute inpatient psychiatric treatment. The length of stay in PHFs is typically short—5 to 7 days. Most PHFs can collect Medicaid reimbursement for persons from 22 to 64 years of age because the hospitals are small enough—16 beds or fewer—to avoid the IMD exclusion. PHFs often receive more Medicaid dollars for services, as a percentage of total budgets, than do the State hospitals. California Welfare & Institution § 5150 authorizes a legal hold imposed on a person that is believed to be in need of involuntary psychiatric treatment in the state of California. The person is believed to be a combination of one or more of the following:

- A Danger to Self
- A Danger to Others
- Gravely Disabled

Once a police officer, or an individual that is 5150 certified**,** has issued a 5150 hold, the person will be taken to a psychiatric or acute care hospital and can be legally held for up to 72 hours. During the first 24 hours of the 3-day hold (72 hours) the person must be evaluated by two psychiatric doctors to determine if admission to the hospital is necessary for further treatment. If both doctors decide the patient is in need of further treatment he/she is admitted into the hospital. Once the 72-hour period is up, the patient has a choice to remain voluntarily. If the patient decides not to stay voluntary, and the doctors (or a RN and a doctor) decides further treatment is necessary, the patient can be Certified with a 5250 for involuntary treatment for up to an additional 14 days.

If a hospital is in a region that does not have adequate mental health beds in non-Acute facilities, it will be more difficult to discharge mental health patients, including 5150 admissions, to psychiatric hospitals and other appropriate settings. If a hospital has mental health beds, it is required to accept mental health patients from the region beyond its own service area, which is a financial impediment to having mental health beds for many hospitals. <u>The availability of mental health beds in the service area has an effect on overall LOS for acute care hospitals.</u>

Medi-Cal LOS

Medi-Cal pays hospitals on both a "per diem" and a "capitated" basis, defined as per regulations established in 2001, as defined below:

Medi-Cal - Traditional - includes patients formerly reported in the Medi-Cal payer category. Hospital reimbursements are either negotiated with the California Medical Assistance Commission or are cost-based, subject to certain limitations, and are paid through the Medi-Cal Fiscal Intermediary.

Medi-Cal - Managed Care - this new payer category includes patients covered by a managed care plan funded by Medi-Cal, and was formerly reported under Other Third Parties. Hospital reimbursements are made directly from the managed care health plan through the Two-Plan Model, County Organized Health Systems, or Geographic Managed Care.

The above information is from the eighth in a series of Hospital Technical Letters developed by the Office of Statewide Health Planning and Development (OSHPD or Office) regarding the uniform accounting and reporting system requirements for California hospitals (Dated – June 2001). The purpose of these letters is to provide timely information to assist hospital CFOs in meeting these requirements. (www.oshpd.cahwnet.gov/HID/hospital/finance/manuals/techletters/HspTechLtr8.pdf)

If a hospital is receiving "per diem" reimbursement for a patient, there is no incentive to discharge the patient in an expeditious manner.

Gov. Arnold Schwarzenegger's (R) administration on June 23, 2005 announced an agreement with the federal government that would increase federal matching funds for Medi-Cal by as much as $3.3 billion over five years and enroll about 500,000 beneficiaries in managed care plans Uncompensated Care/Charity Care, the Los Angeles Times reports (Rau/Ornstein, *Los Angeles Times*, 6/23).

Under the plan, California would receive a five-year waiver from federal rules regarding hospital payments for Medi-Cal. The waiver would allow the state to continue contracting with 230 hospitals for Medi-Cal services, rather than pay the 600 hospitals statewide. State officials say the agreement would save California money and help it to comply with federal accounting requirements.

The federal government would provide the state with an additional $671 million annually for the program over five years. Of that money, $360 million has been earmarked to shift low-income beneficiaries to managed care plans (Lawrence, AP/ Contra Costa Times, 6/23). According to state officials, 554,000 elderly, blind and disabled state residents would be moved to managed care plans between January 2007 and mid-2008 under the plan (*Los Angeles Times*, 6/23).

Uncompensated Care

Uncompensated care is generally referred to as the sum of pure charity care and bad debt. Using Annual Financial Disclosure Report data provided by the California Office of Statewide Planning and Development (OSHPD), this policy brief discusses the provision of uncompensated care delivered by California hospitals from 1998 to 2000. Although the term "charity care" is often used to describe a variety of measures, in this instance we use the term "pure charity care" to indicate two line items on the Annual Disclosure Report: (1) dollar amounts of charity care provided designated as fulfilling a Hill-Burton requirement, and (2) "charity care-other." A large majority of the pure charity care reported is found in the "charity care-other" category. Over the three-year period, the number of hospitals decreased slightly while the amount of uncompensated care rose from almost $900,000,000 to over $1,000,000,000 from 1998 to 2000, after adjusting for inflation. When dividing the uncompensated care amount by total operating expenses, the average percent of total operating expenses attributed to uncompensated care is 3.41% over the three-year average.

Outline of Petris Center Policy Briefs Regarding Uncompensated Care

The majority of uncompensated care (61 percent) is provided by nonprofit hospitals, followed by government hospitals (18 percent), investor-owned hospitals (15 percent) and district hospitals (6 percent). While nonprofit hospitals provide a majority of uncompensated care in California, they also make up the largest share of hospitals and staffed beds in the state. The major findings of this Policy Brief are two-fold:

Government hospitals, primarily county facilities, provided more than twice as much uncompensated care per bed as nonprofit hospitals and more than three times as much as investor-owned hospitals.

There is large variation within ownership groups in the level of uncompensated care as a percent of total operating expenses, ranging from approximately one percent or less for both non-profits and for-profits in the bottom ten percent to approximately six percent or more for those in the top ten percent.

Uncompensated Care Provided as a Percent of Total Operating Expenditures

Hospital Type	10th Percentile	50th Percentile	90th Percentile
District	1.7	3.4	6.0
Government	0.3	4.6	11.0
Investor	0.9	2.5	6.0
Nonprofit	1.2	2.5	6.0

The California Hospital Association Board of Trustees adopted the California Hospital Billing and Collection Practices Voluntary Principles and Guidelines for Assisting Low-Income Uninsured Patients on February 6, 2004. (www.calhealth.org/Download/VolPrinciplesGuidlines204.pdf) Here are some relevant excerpts:

By mission and by law, hospitals provide care to anyone who needs help, regardless of their ability to pay. Unfortunately, California's health care system is fragmented — with millions of people unable to afford the health care services they need. Nearly 7 million Californians — one out of every five people — have no health insurance, and another 3 million residents are underinsured. California hospitals provide nearly $4 billion annually in uncompensated care. A confusing array of governmental laws, rules and regulations currently make it difficult for hospitals to respond to the needs of those patients who truly cannot afford the health care services they receive.

Regulatory reform is needed to enable hospitals to effectively respond to the individual needs of low-income uninsured patients. CHA anticipates that the U.S. Department of Health and Human Services will shortly provide guidance on how hospitals across the country can appropriately bill the uninsured. CHA will provide further information as it becomes available, and will make any revisions that may be necessary to these *Voluntary Principles and Guidelines.* In the meantime, CHA urges its member hospitals to adopt the following principles and guidelines to better meet the needs of those patients who truly cannot afford the health care services they receive.

PRINCIPLES

- Each hospital should have financial assistance policies that are consistent with the mission and values of the hospital. These policies, which should be broadly communicated, should reflect a commitment to provide financial assistance to patients who cannot pay for part or all of the care they receive.

- Financial assistance policies must balance a patient's need for financial assistance with the hospital's broader fiscal responsibilities.

- Debt collection policies — by both the hospital and its external collections agencies — must reflect the mission and values of the hospital.

- Financial assistance provided by the hospital is not a substitute for personal responsibility. All patients should be expected to contribute to the cost of their care, based upon their individual ability to pay.

GUIDELINES ***Financial Assistance Policies for Low-Income Uninsured Patients***

- Each hospital should maintain understandable, written financial assistance policies for low-income uninsured patients, addressing both the hospital's charity care policy, as well as its discount payment policy for the low-income uninsured.

- Absent any regulatory prohibition, each hospital should limit expected payments from these patients eligible for financial assistance to amounts that do not exceed the payment the hospital would receive from Medicare, other government-sponsored health programs, or as otherwise deemed appropriate by the hospital.

Governmental Requirements & Restrictions

The Emergency Medical Treatment and Active Labor Act is a statute, which governs when, and how a patient may be (1) refused treatment or (2) transferred from one hospital to another when he is in an unstable medical condition. It is included as part of the section of the U.S. Code which governs Medicare.

EMTALA applies only to "participating hospitals" -- i.e., to hospitals which have entered into "provider agreements" under which they will accept payment from the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) under the Medicare program for services provided to beneficiaries of that program. In practical terms, this means that it applies to virtually all hospitals in the U.S., with the exception of the Shriners' Hospital for Crippled Children and many military hospitals. Its provisions apply to all patients, and not just to Medicare patients.

The avowed purpose of the statute is to prevent hospitals from rejecting patients, refusing to treat them, or transferring them to "charity hospitals" or "county hospitals" because they are unable to pay or are covered under the Medicare or Medicaid programs. If the patient does not have an "emergency medical condition", the statute imposes no further obligation on the hospital. A pregnant woman who presents in active labor must, for all practical purposes, be admitted and treated until delivery is completed, unless a transfer under the statute is appropriate. Note that the determination of whether a woman in labor falls under the definition of "emergency medical condition" is determined by consideration of time factors -- whether there is adequate time to effect a "safe transfer" to another hospital before delivery. (If the woman is not in labor, that is, is not having contractions, then she does not fall under the terms of the statute unless her condition fits the general definition of "emergency medical condition" under the first paragraph for some other medical reason.)

Medicare HMO

From a report by Catteneo and Stroud, “Kaiser and PacifiCare together control 75 percent of the Medicare HMO market. Kaiser enrollment increased slightly (0.7%), whereas Pacificare lost slightly (0.9%).”

Thirty-five percent of all California Medicare beneficiaries are enrolled in a Medicare+Choice plan, far in excess of the 14 percent rate nationwide. This report seeks to identify what lessons for the nation can be drawn from the California M+C experience, as Congress debates the implications of major withdrawals from the M+C program and potential policy changes aimed at reversing this trend. The report is based largely on analysis of M+C data on plan participation, withdrawals, and enrollment by county from year-end 1997 (when M+C was enacted) through 2001, including reported withdrawals in 2002. (Source – Kaiser Family Foundation, 2002) For 2004, California Medicare Advantage plans had a market penetration of 31%. Penetration is the number of enrollees in Medicare Advantage divided by the number of Medicare beneficiaries. Typically, managed care providers aggressively manage cases, resulting in lower LOS than that for other payor types.

Key Senior Consulting findings on LOS

Statewide Data

Statewide, based on hospital annual financial data covering report periods ending in 2004 submitted to OSHPD, there were 364 General Acute Care hospitals with 82,450 beds, with Total Census Days of 18,233,725 and 3,231,386 discharges resulting in a Statewide LOS of 5.64. There were 46 licensed hospitals that failed to provide their utilization data for 2002. The Analysis did not include hospitals licensed for children, psychiatric care, rehabilitation or chemical dependency. The average hospital in the state has 209 beds, with an average Total Census Days of 50,092. **The statewide LOS of 5.64 is approximately 34% more than the Geometric Mean Length of Stay ("GMLOS") of 4.20**, the national average for LOS. If Children's, Psychiatric, and Rehabilitation hospitals are eliminated from the calculation, it is estimated that there would be a 5% reduction in the GMLOS, with an estimated 8% savings resulting from the implementation of the Post-Acute strategies similar to those offered by Senior Consulting, LLC. **Therefore, 3.67 should be the maximum-targeted LOS for the majority of California Hospitals.**

The variance in LOS from hospital to hospital was substantial. 50.2% of the hospitals in the State had a LOS that was less than 90% of the average LOS, or 5.08, and 36.8% of the hospitals in the State had a LOS that was less than 80% of the average LOS, or 4.52. 28.6% of the hospitals in the State had a LOS that was more than 110% of the average LOS, or 6.20, and 23.6% of the hospitals in the State had a LOS that was more than 120% of the average LOS, or 6.76. See Figure (1).

Figure (1)

Variance in LOS (1)	1.97
Average Loss per Patient Day (2)	$4,341.00
Number of Cases (3)	8,877
Gross Reducible Charges (4)	$75,914,062.29
Contractual Allowances (85%)	$64,526,952.95
Net Lost Revenue	$11,387,109.34
Discharge to SNFs (10.6%) (5)	10.6%
Adjusted Net Lost Revenue	$1,207,033.59
Projected Net Lost Revenue (60%) (6)	$724,220.15

Los Angeles County

Los Angeles County has an average LOS that is approximately 36% higher than the GMLOS. A 1.15 **reduction in LOS for an average hospital in Los Angeles County would result in $511,112.69 annually** being added to a hospital's contribution margin or profit. In Los Angeles County, as of December 31, 2004, there were 90 general acute hospitals with 23,500 beds, with Total Census Days of 5,517,813 days resulting in a Los Angeles County Average LOS of 5.71. Figure (2) below demonstrates the average Benefit to contribution margins for an average Los Angeles general acute hospital based on the average number of cases in the County:

Figure (2)

Variance in LOS (1)	2.04
Average Loss per Patient Day (2)	$4,341.00
Number of Cases (3)	10,732
Gross Reducible Charges (4)	$95,038,728.48
Contractual Allowances (85%)	$80,782,919.21
Net Lost Revenue	$14,255,809.27
Discharge to SNFs (10.6%) (5)	10.6%
Adjusted Net Lost Revenue	$1,511,115.78
Projected Net Lost Revenue (60%) (6)	$906,669.47

Sample of Existing Hospital

A review of a detailed analysis of all census data for a Southern California Hospital having over 350 beds in 2004 shows a total of 18,562 patients. See Figure (3).

Figure (3)

Variance in LOS (1)	0.96
Average Loss per Patient Day (2)	$4,341.00
Number of Cases (3)	18,562
Gross Reducible Charges (4)	$77,354,536.32
Contractual Allowances (85%)	$65,751,355.87
Net Lost Revenue	$11,603,180.45
Discharge to SNFs (10.6%) (5)	10.6%
Adjusted Net Lost Revenue	$1,229,937.13
Projected Net Lost Revenue (60%) (6)	$737,962.28

(1) The National average or Geometric Mean Length of Stay ("GMLOS") is 4.20. There is an estimated reduction of 5% in the GMLOS by eliminating the Psychiatric, Chemical Dependency, Specialty, Rehabilitation, and Children's Hospitals. If targeting only an 8% savings based on expanded Post-Acute strategies as suggested by the Health Care Advisory Board, the Targeted Average LOS would be 3.67. The Variance in LOS represents the difference between the Hospital's LOS and the Targeted Average LOS.

(2) Based on experience of a 200+ bed hospital in Bay Area in 2003, actual results may vary.

(3) Based on number of discharges reported to OSHPD for 2004.

(4) Represents the Variance in LOS times the Average Loss per Patient Day times the Number of Cases.

(5) Based on experience of a 200+ bed hospital in Bay Area in 2003, actual results may vary. The proportion of all patients discharged from that hospital that went to Skilled Nursing Facilities was 10.6%.

(6) Based on experience at other acute care hospitals, 60% of discharges are Medicare patients; therefore, the adjustment of 60% is utilized herein to obtain Projected Net Lost Revenue.

* Data summarized in the same manner as Figures (1), (2) and (3) on a County or Regional basis and for **each** individual hospital, weighted to the targeted LOS as mentioned herein or weighted within the County, as well as supporting documentation, is available and/or included in the final Analysis.

Conclusion

California LOS is approximately 34% above the GMLOS. There is a substantial variance in LOS in CA, from hospital to hospital within each region, and County to County. LOS in Los Angeles County is approximately 36% above the GMLOS and substantially higher than the remainder of the State. Some hospitals implement plans to limit and/or reduce Medicare LOS, since the optimization of LOS for a substantial portion of patients can result in the maximum income possible while reducing expenditures. However, there is opportunity in the industry overall

Regional and Type of Ownership Transfer Discharge Analysis

SC completed individual Analysis of Transfer DRGS utilizing the three groupings of Top 25 data available from OSHPD for 91 hospitals individually and collectively within three regions for County, District and Nonprofit Hospitals and For Profit Hospitals. This represented the overwhelming majority of hospitals with 100-499 beds; not including those owned by systems that own/operate five of more hospitals or 1,000 beds or more.

Three separate analyses were completed for Northern California, Southern California and Central Valley Transfer Discharge Analysis, as well as an analysis of For Profit Hospitals. These reports, attached as Exhibits C, D, E and F, include a Summary that projected Net Losses, as well as Number of Discharges, ALOS, Charges, and Frequency for each hospital and by grouping, as well as Transfer Discharges within each grouping by each of the regions for the County, District and Governmental, and well as For Profit Hospitals.

SC's Analysis includes one hospital in Northern California and 20 in Southern California of the 26 total For Profit hospitals, one of which was only rehabilitation. For the Central Valley, SC's Analysis includes two County hospitals, five District hospitals and 10 Nonprofit hospitals. For Northern California, SC's Analysis includes three County hospitals, five District hospitals and nine of the 10 Nonprofit hospitals. Lastly, for Southern California, SC's Analysis includes four of seven County hospitals, nine District hospitals and 22 of 31 Nonprofit hospitals.

For many diagnoses, such as Psychoses and Pneumonia, there was a substantial variance in regions and based on type on ownership, as well as within each hospital.

Following is a comparative analysis of the top ten Discharges for each of the separate Analyses referenced above:

Type/Region (2)	% of Total Transfer DRGs	DRGs (1) 430	127	89	296	416	320
For Profit	77.8%	21.3%	13.7%	11.4%	5.1%	5.1%	4.8%
Central Valley	77.9%	5.8%	16.8%	18.7%	5.9%	5.7%	5.3%
Northern California	81.3%	23.1%	12.9%	9.8%	5.4%	4.5%	2.2%
Southern California	79.3%	17.9%	15.4%	12.3%	4.5%	4.0%	4.4%

	475	462	79	14	148
For Profit	4.2%	3.7%	3.6%	3.1%	2.0%
Central Valley	4.0%	3.5%	1.7%	6.5%	4.1%
Northern California	2.4%	10.1%	3.0%	5.1%	2.8%
Southern California	3.3%	7.5%	1.2%	6.1%	2.6%

NOTES

(1) This Analysis by Senior Consulting, LLC ("SC") includes the Top 10 Transfer DRGs for each Type/Region, which represented 11 DRGs within all four groups. The DRGs are listed in the order they appear for the For Profit group of hospitals.

430	PSYCHOSES
127	HEART FAILURE & SHOCK
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC
416	SEPTICEMIA AGE >17
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC
475	RESPIRATORY SYS DIAG W VENTILATOR SUPORT
462	REHABILITATION
79	RESP INFECTN AGE >17 W CC
	INTRACRANIAL HEMORRHAGE & STROKE W
14	INFARCT
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC

(2) SC's Analyses include the review and compilation of data submitted to OSHPD for 2004 by hospitals having 100-499 beds that are not owned by chains operating five or more hospitals and/or 1,000 beds or more. For each of the three geographical regions, our review included hospitals owned by nonprofits, healthcare districts, and cities/counties.

Mental Health and Psych Discharges

Background

The California Department of Mental Health (DMH) certifies Special Treatment Programs (STPs) at SNFs. STP certification requires the provision of "programs aimed at improving the adaptive functioning of chronically mentally disordered patients to enable some patients to move into a less restrictive environment and prevent other patients from regressing to a lower level of functioning." STP programs must provide a minimum of 27 hours per week of direct group or individual rehabilitative services in the following areas: self-help skills, behavior adjustment, interpersonal relations, prevocational preparation, and prerelease planning. Since the SNFs are also licensed by the Department of Health Services, they have to pay two annual licensing fees and are subject to oversight from both Departments. In 2001, there were 34 SNF/STPs with a total of 3,384 beds. As of April 21, 2006, there were 10 Skilled Nursing Facilities w/ Certified Special Treatment Programs in California.

The state sets an average daily private pay rate for nursing facilities, which does not include charges for ancillary services such as physical therapy, speech therapy, audiology, laboratory, and patient supplies and or prescription drugs. In addition, SNFs receive a per capita daily rate of $5.72 for the Specialized Treatment Program. A county may also pay the facility a supplemental rate (so-called "patch") for certain individuals placed at SNF/STPs, although the amount (perhaps as much as $3,000.00 a month) and frequency of such subsidies is unclear.

Total patient capacity at Mental Health Rehabilitation Centers (MHRCs) has increased 100% since realignment because this type of facility did not exist until 1995. The state intended to establish MHRCs to address inadequate access to home- and community-based mental health services in California. MHRCs are licensed by the Department of Mental Health. The MHRCs negotiate individual contracts with DMH and the counties whose patient reside at the MHRC. As of June 2001, there were 18 MHRCs in 15 counties with a total capacity of 1,283 beds. As of April 21, 2006, there were 26 Mental Health Rehabilitation Centers in California.

With higher labor costs, Patch funds from a city or county are required to operate a SNF/STP on a breakeven basis. Mental Health Rehabilitation Centers (MHRCs) require less nursing staff than SNFs but more counseling staff. The overall expenses for staffing can be comparable on a per patient basis at a MHRC.

Psychoses Diagnosis and DRG 430

Below is a Summary of Psychoses Discharges:

Type/Region (1)	# of Discharges	% of Total Transfer DRGs	# of Hospitals	# of Hosp. in Type/Region	ALOS (2)
For Profit	6,930	21.3%	7	21	9.4
Central Valley (3)	1,727	5.8%	2	17	14.5
Northern California	7,937	23.1%	9	17	8.4
Southern California	13,813	17.9%	16	35	9.1

NOTES

(1) Senior Consulting, LLC's ("SC") Analyses include the review and compilation of data submitted to OSHPD for 2004 by hospitals having 100-499 beds that are not owned by chains operating five or more hospitals and/or 1,000 beds or more. For each of the three geographical regions, the review included hospitals owned by nonprofits, healthcare districts, and cities/counties.

(2) The ALOS shown is the unweighted average of the ALOS for each hospital in the Type/Region having the indicated DRG.

(3) SC excluded from this region the data for two hospitals, Emanuel Medical Center and Oak Valley District Hospital, which had a total of seven discharges in DRG 430, because Emanuel's ALOS was 859.8 and Oak Valley's was 84.7.

Psychoses Discharge Conclusions

With more MHRC’s located in the Central Valley, hospitals admit and therefore discharge a much lower percentage of Psychiatric patients. In Southern California, For Profit Hospitals meet a much larger portion of this need than in Northern California, where County Hospitals meet this need.

With the high number of Psychoses discharges for many hospitals, with a shortfall of long term care options in many areas of the state, including many of the Bay Area Counties and in Greater Los Angeles, there is a need for additional long term care options for Hospitals.

Rehabilitation Diagnosis and DRG 462

Below is a Summary of Rehabilitation Discharges:

Type/Region (1)	# of Discharges	% of Total Transfer DRGs	# of Hospitals	# of Hosp. in Type/Region	ALOS (2)
For Profit	1,191	3.7%	6	21	51.3
Central Valley	1,039	3.5%	4	17	13.9
Northern California	3,468	10.1%	10	17	15.3
Southern California	5,806	7.5%	16	35	15.9

NOTES

(1) Senior Consulting, LLC's ("SC") Analyses include the review and compilation of data submitted to OSHPD for 2004 by hospitals having 100-499 beds that are not owned by chains operating five or more hospitals and/or 1,000 beds or more. For each of the three geographical regions, the review included hospitals owned by nonprofits, healthcare districts, and cities/counties.

(2) The ALOS shown is the unweighted average of the ALOS for each hospital in the Type/Region having the indicated DRG.

Rehabilitation Discharge Conclusions

Northern California hospitals have by far the highest percentage of Hospitals admitting/discharging Rehabilitation patients within the groupings of hospitals, yet only six of the 17 hospitals in the analysis have SNF beds in their system, a likely destination for Rehabilitation patients. This presents an opportunity for many hospitals in establishing expanded relationships with skilled nursing facilities that desire these patients in combination with expanding discharges of other difficult to place patients. To a somewhat lesser extent, these options are available for many Southern California hospitals.

With a substantially higher percentage of hospitals in the Central Valley operating SNF beds and having a lower percentage of Rehabilitation admissions/discharges, there is limited opportunity to improve rehabilitation access for patients within the full continuum in the Central Valley. While there are only 6 of the 21 For Profit hospitals discharging Rehabilitation patients, the ALOS is extremely high within this group. This indicates that while there may a great need for improvement in the ability to discharge rehab patients within this group, there may be mitigating circumstances or additional reimbursement sources that could only be determined with an internal analysis of each of these hospitals.

Heart Failure Diagnosis and DRG 127

Below is a Summary of Heart Failure Discharges:

Type/Region (1)	# of Discharges	% of Total Transfer DRGs	# of Hospitals	# of Hosp. in Type/Region	ALOS (2)
For Profit	4,446	13.7%	21	21	5.1
Central Valley	4,970	16.8%	17	17	5.8
Northern California	4,429	12.9%	16	17	4.9
Southern California	11,846	15.4%	35	35	5.9

NOTES

(1) Senior Consulting, LLC's ("SC") Analyses include the review and compilation of data submitted to OSHPD for 2004 by hospitals having 100-499 beds that are not owned by chains operating five or more hospitals and/or 1,000 beds or more. For each of the three geographical regions, the review included hospitals owned by nonprofits, healthcare districts, and cities/counties.

(2) The ALOS shown is the unweighted average of the ALOS for each hospital in the Type/Region having the indicated DRG.

Heart Failure Discharge Conclusions

As expected, this diagnosis is almost universal, as it was in the Top 25 for every hospital but one in the study, often in the Top Five. Percentages of Discharges and ALOS are consistent within the various regional and type of ownership groupings. A substantial percentage of these discharges would be discharged to skilled nursing facilities, again presenting an opportunity for many hospitals in establishing expanded relationships with skilled nursing facilities that desire these patients in combination with expanding discharges of other difficult to place patients.

Stroke Diagnosis and DRG 14

Below is a Summary of Stroke Discharges:

Type/Region (1)	# of Discharges	% of Total Transfer DRGs	# of Hospitals	# of Hosp. in Type/Region	ALOS (2)
For Profit	1,010	3.1%	12	21	6.6
Central Valley	1,931	6.5%	14	17	11.1
Northern California	1,742	5.1%	12	17	5.8
Southern California	4,720	6.1%	28	35	5.5

NOTES

(1) Senior Consulting, LLC's ("SC") Analyses include the review and compilation of data submitted to OSHPD for 2004 by hospitals having 100-499 beds that are not owned by chains operating five or more hospitals and/or 1,000 beds or more. For each of the three geographical regions, the review included hospitals owned by nonprofits, healthcare districts, and cities/counties.

(2) The ALOS shown is the unweighted average of the ALOS for each hospital in the Type/Region having the indicated DRG.

Stroke Diagnosis Conclusions

Patients with this diagnosis in the Central Valley had an average stay almost twice as long as that of patients in the other regions, indicating an increased opportunity for improved contribution margins in this region with improved focus on this directive. Like Heart Failure, a substantial percentage of these discharges would be discharged to skilled nursing facilities, again presenting an opportunity for many hospitals in establishing expanded relationships with skilled nursing facilities that desire these patients in combination with expanding discharges of other difficult to place patients.

Nutritional and Metabolic Diagnosis and DRG 296

Below is a Summary of Nutritional and Metabolic Discharges:

Type/Region (1)	# of Discharges	% of Total Transfer DRGs	# of Hospitals	# of Hosp. in Type/Region	ALOS (2)
For Profit	1,652	5.1%	19	21	4.4
Central Valley	1,745	5.9%	15	17	6.5
Northern California	1,868	5.4%	16	17	11.8
Southern California	3,479	4.5%	27	35	4.4

NOTES

(1) Senior Consulting, LLC's ("SC") Analyses include the review and compilation of data submitted to OSHPD for 2004 by hospitals having 100-499 beds that are not owned by chains operating five or more hospitals and/or 1,000 beds or more. For each of the three geographical regions, the review included hospitals owned by nonprofits, healthcare districts, and cities/counties.

(2) The ALOS shown is the unweighted average of the ALOS for each hospital in the Type/Region having the indicated DRG.

Nutritional and Metabolic Diagnosis Conclusions

Patients with this diagnosis in Northern California had an ALOS that is substantially higher than other regions, indicating an increased opportunity that will benefit contribution margins based on improved discharge of patients to skilled nursing facilities

Acute and SNF Solutions for Mutual Benefits

Hospital Management is aware of the incentives to improve their Post-Acute discharges, including improvements in contribution margins by a reduction in the Length Of Stay ("LOS") for certain Medicare patients, even though financial data is rarely available on Transfer DRGs only. With so many responsibilities, regulations and restrictions facing hospital executives and management, even the best post acute strategic planning often falls short in actual implementation without added support, let alone the expanding Post-Acute strategies, such as these potential solutions:

- Complete an internal financial assessment of Transfer DRGS, sorted by groupings of patients that exceeded LOS, those that were within 20% of targeted LOS or less and those that are a day or more less than the LOS. These separate analyses, not completed and typically available within IT systems to management, demonstrate the substantial improvement in contribution margins available and provide a basis to quantify improvements in discharges quarter to quarter thereafter.

- Review clinical appropriateness of transfer discharges that exceeded targeted LOS within the framework of existing discharge options and as though there were SNF(s) with Subacute-level nursing skills sets available for discharge of complex Medicare patients, let alone Medi-Cal patients, including recommendations of clinical criteria assuming higher acuity post acute option(s) are developed.

- Complete an analysis of the SNF market to establish the best existing and potential options for patients, including input from discharge planners, review of SNF compliance history, staffing, physical plant condition and senior management commitment.

- Establish affiliations and arrangements with SNFs based on the initial analysis to help hospitals discharge difficult to place patients such as Psychiatric or Dialysis patients.

- In addition to focusing on "hard to place" patients, SNFs in the hospital's service area should be prodded to expand hours for admissions, often 24/7, expand rehabilitation coverage to six days per week, and participate in the creation of a uniform discharge process for SNFs in the hospital's service area.

- An informal or formal Post-Acute and/or SNF network should be established, which can also include an e-Discharge System, improving discharges and saving staff time for more important tasks.

- Consideration of the hospital to offer education and training to skilled nursing facilities should be considered, either directly or from a third party provider. The improved skill sets in the skilled care setting would benefit the hospital, as many patients with a high LOS, such as many requiring IV therapy, would become clinically appropriate to discharge to the skilled nursing facility.

- Expanded involvement of physicians on a to be established or modified, "Post-Acute Team" or "SNF Team" will result in substantially improved physician confidence in SNFs and improved discharges, particularly when a SNF network is established, improving discharges of difficult to place patients.

- The establishment of a SNF network or expanded synergies with SNFs will result in ancillary benefits to the hospital, including expanded referrals to the hospital from area SNFs for various outpatient services.

Conclusions

With experienced support, these services can be implemented with minimal input from management, nursing, finance and discharge planners, the staff members that may later serve as integral parts of the Post-Acute Team to assist in improved relationships and potential additional services with long term care facilities, and maintain the network, if applicable. A Post-Acute Team should be established, with a team leader, either internally or a third party, experienced in both acute and skilled care perspectives.

Exhibit A

California Skilled Nursing Facilities
Statewide and Regional Variances
Occupancy and Payer Mix

Exhibit A

California Skilled Nursing Facilities
Statewide and Regional Variances
Occupancy and Payer Mix

Introduction

Senior Consulting, LLC, ("SC"), conducted a review of the financial data for 2004 reported to the Office of Statewide Health Planning and Development, "OSHPD", by California Skilled Nursing Facilities, "SNFs." In addition, we analyzed occupancy and payor mix data for all chains of SNFs with three to nine facilities and those with 10 or more facilities collectively and individually, and reviewed press releases and websites of larger operators. All data was weighted and compared between these grouping of facilities. Furthermore, SC analyzed data for facilities that are affiliated with no more than one other SNF. SC examined occupancy percentages and payor mix for facilities statewide and within each size grouping, including overall occupancy and the four payor types -- Medicare, Medi-Cal, Private Pay, and HMO/Other.

In 2004, 1,134 SNFs, including those with Residential beds, reported financial data to OSHPD. 144 SNFs had licensed Residential beds. 990 SNFs did not have any Residential beds. Of those 990 facilities, 566 SNFs were either unaffiliated or associated with just one other facility. Chains with three to nine facilities owned 106 SNFs. Chains with 10 or more facilities owned 318 SNFs.

SC is aware of at least one chain with ten (10) locations that was not classified in the OSHPD data as being a chain or having a Parent Company. Therefore, assuming a minor adjustment, we estimate that 40% of the SNFs in California, not including those with Residential beds, are owned by chains or parent companies owning ten or more facilities, with 12-15% of the facilities owned by chains of 3-9 facilities and a minimum of 55% of the SNFs in the State owned by "Mom and Pop" operators of 1-2 facilities.

In addition, SC completed a detailed census and payor mix analysis for five regions: Alameda, Contra Costa, Sacramento, Los Angeles and Orange Counties and a less detailed analysis of six other Bay Area counties. While payor mix for all categories except Medi-Cal varied substantially for different groups of operators Statewide, the variances in payor mix and occupancy, including Medicare, Private and Managed Care patients, were extreme in each of these regions. These variances indicate a substantial need for the industry to reassess strategic planning and marketing strategies, both internally and in engaging professional guidance.

Statewide Occupancy and Payor Mix Variances

Statewide SNFs, with and without residential beds

Overall occupancy and payor mix statewide, which includes all facilities in the State except facilities that did not report utilization data to OSHPD. These data include facilities that had both skilled care beds and residential healthcare beds

Including the Facilities that had licensed SNF and Residential Beds:

- Statewide, the Occupancy percentage for all SNFs is 86.4%.
- Statewide, the Medicare percentage for all SNFs is 10.0%.
- Statewide, the Medi-Cal percentage for all SNFs is 66.6%.
- Statewide, the Private Pay percentage for all SNFs is 15.0%.
- Statewide, the Managed Care/Other percentage for all SNFs is 8.5%.

Excluding the Facilities that had licensed SNF and Residential Beds:

- Statewide, the Occupancy percentage for these SNFs is 86.4%.
- Statewide, the Medicare percentage for these SNFs is 10.0%.
- Statewide, the Medi-Cal percentage for these SNFs is 69.2%.
- Statewide, the Private Pay percentage for these SNFs is 12.5%.
- Statewide, the Managed Care/Other percentage for these SNFs is 8.3%.

Senior Consulting, LLC reviewed the OSHPD data and classified the SNFs into four categories – Facilities associated with no more than one other facility; Chains having three to nine facilities; chains having 5-9 facilities and Chains having 10 or more facilities.

SNFs affiliated with no more than one other Facility

Senior Consulting, LLC extracted data for SNFs not associated with more than one other facility. It eliminated all facilities affiliated with a Chain of three or more facilities or having a common name with more than one other facility. These Facilities had an increased utilization by Private Pay residents but a lower use by HMO/Other, which may reflect a weaker bargaining position with HMOs since the coverage area is less.

- Statewide, the Occupancy percentage for all SNFs is 86.4%; the Occupancy percentage for SNFs affiliated with no more than one other facility is 87.0%.

- Statewide, the Medicare percentage for all SNFs is 10.0%; the Medicare percentage for SNFs affiliated with no more than one other facility is 9.0%.

- Statewide, the Medi-Cal percentage for all SNFs is 66.6%; the Medi-Cal percentage for SNFs affiliated with no more than one other facility is 67.6%.

- Statewide, the Private Pay percentage for all SNFs is 15.0%; the Private Pay percentage for SNFs affiliated with no more than one other facility is 15.6%.

- Statewide, the Managed Care/Other percentage for all SNFs is 8.5%; the Occupancy for SNFs affiliated with no more than one other facility is 7.7%.

Chains with three to nine SNFs

Senior Consulting, LLC extracted data from OSHPD for SNFs associated with Chains of three to nine facilities. These Facilities had a marked increase in Occupancy, Private Pay and HMO/Other utilization when compared to facilities statewide. This is partially due to their ability to have a dedicated marketing staff within the management of all the facilities. There are a number of small chains in this grouping that have long standing family ownership and likely better reputations overall than larger chains, which is reflected in the substantial difference in Private Pay census, which is almost fifty percent (50%) higher for chains that own three to nine facilities than for chains of ten or more.

- Statewide, the Occupancy percentage for all SNFs is 86.4%; the Occupancy percentage for chains having three to nine facilities is 88.9%.

- Statewide, the Medicare percentage for all SNFs is 10.0%; the Medicare percentage for chains having three to nine facilities is 8.4%.

- Statewide, the Medi-Cal percentage for all SNFs is 66.6%; the Medi-Cal percentage for chains having three to nine facilities is 61.5%.

- Statewide, the Private Pay percentage for all SNFs is 15.0%; the Private Pay percentage for chains having three to nine facilities is 18.0%.

- Statewide, the Managed Care/Other percentage for all SNFs is 8.5%; the Occupancy percentage for chains having three to nine facilities is 12.1%.

There are a total of 59 facilities owned by 16 operators with 3-4 facilities each, which have not been reviewed separately.

Chains with Five to Nine SNFs

These are the only chains that own between 5-9 facilities in California as per OSHPD data, although one operator maintains they operate or manage additional facilities:

Name of Chain	Total Facilities	# of Beds	Overall Occupancy	Medicare Occupancy	Private Pay Occupancy	Managed Care Occupancy	Medi-Cal Occupancy
Employee Equity Administration	8	860	90.5	5.5	21.5	7.1	65.9
Ocadian (2)	7	828	76.3	15.2	28.5	18.7	37.6
Avalon Healthcare (	8	737	90.5	11.7	10.1	2.7	75.4
Helping Hands Sanctuary of Idaho	6	687	82.5	7.6	10.7	4	77.8
PAKSN Inc t/a Care Systems Inc	7	651	90.5	8.7	9.6	4.2	77.5
Braswells	5	533	92	2.5	8.9	19.1	69.5
Independent Care/ Foresight Mgmt.	6	311	75.7	5.3	22.9	3.1	68.7
Totals (4)	47	4607	85.4	8.1	16.0	8.4	67.5

Disclaimer - The data utilized herein was obtained at the OSHPD Web site and current as of December 31, 2004. However, OSHPD indicates the data is not necessarily 100% accurate because of possible reporting errors by the facilities and the methods of aggregation.

NOTES

(1) Facilities are ranked by the total number of beds in the skilled care facilities owned by the chain as referenced in OSHPD data. In addition, some owners of multiple facilities with common management own facilities through separate entities, which may not be included herein.

(2) According to the chain's Web site, they have additional facilities, both skilled care and Subacute that they operate and/or manage.

(3) Avalon Healthcare is a national chain based in Utah with a total of 33 SNFs in four additional States.

(4) Occupancy Percentages are the average per chain, not weighted by the total beds per chain or overall.

Chains with 10 or more SNFs

Following are all chains of ten or more in the State of California with occupancy and payor mix:

Name of Chain	Total Facilities	# of Beds	Overall Occupancy	Medicare Occupancy	Private Pay Occupancy	Managed Care Occupancy	Medi-Cal Occupancy
Pleasant Care Corp.	29	4,351	78.5	10	8.1	4.9	77.5
Country Villa	34	3,451	88.6	10.7	14.2	12.8	62.2
SavaSenior Care/ Mariner	29	3,371	84	12.9	13.9	9.3	63.9
Horizon West	24	2,658	77.4	5.8	12.4	10.5	71.3
Covenant Care	22	2,591	89.9	15.5	13	5.6	65.9
Ensign Group	25	2,564	84.7	13.2	12.9	9.8	64
Fillmore Capital/ Beverly	25	2,407	87.2	8.4	10.5	5.5	75.7
Skilled Healthcare	21	2,293	82.9	16.7	9.7	8.7	64.8
Kindred	18	2,142	91.1	14.3	12.9	12	60.9
Windsor/Meritcare (2)	15	1,944	89.6	13.4	7	4.4	75.2
Evergreen Healthcare	15	1,762	73.5	11.4	9.7	6	73
Helios Healthcare	13	1,600	88.4	9.7	9.8	5.8	74.7
Sun Healthcare Inc	19	1,518	84.5	11.3	12.2	12.8	63.8
HCR Manor Care	10	1,388	84	22.5	31.9	13	32.7
Life Care Centers of America (3)	12	1,310	88.4	12.5	13.5	14.8	59.2
Riverside Healthcare	10	1,069	85.8	7.4	11.2	8.1	80.1
Kennon S Shea & Co.	10	738	88.3	3.6	25.1	12.6	58.7
Life Generations	10	648	91.7	16.8	12.7	9.6	61
Totals (4)	341	37,805	85.5	12.0	13.4	9.2	65.8
Averages (5)			84.6	12.2	12.2	8.4	67.1

Disclaimer - The data utilized herein was obtained at the OSHPD Web site and current as of December 31, 2004. However, OSHPD indicates the data is not necessarily 100% accurate because of possible reporting errors by the facilities and the methods of aggregation.

NOTES

(1) Facilities are ranked by the number of beds owned by a skilled care chain in California as referenced in OSHPD data, which does not include one facility for Country Villa and two facilities for Ensign Group that have residential beds. None of the other chains with ten or more facilities have any residential beds. In addition, some owners of multiple facilities with common management own facilities through separate entities. Senior Consulting is aware of one such ownership structure with 11 facilities, not included herein.

(2) On September 1, 2005, SnF Management, a provider of long-term healthcare and rehabilitation services operated under the Windsor name, acquired six SNFs from Meritcare, Inc.

(3) Life Care Centers of America is one of the largest national chains for skilled care facilities, in addition to being one of the largest operators of life care facilities.

(4) Occupancy Percentages are the average per chain, not weighted by the total beds per chain or overall.

(5) Based on Analysis prepared by Senior Consulting, LLC of OSHPD data. The Occupancy and Payer percentages are weighted based on actual number of patient days for census and each payer as per sorted data and defined chain ownership from OSHPD, which includes approximately 97% of the facilities in this Analysis.

Chains with 10 or more facilities had a marked increase in Medicare utilization when compared to facilities statewide. This is partially due to their ability to have a more comprehensive rehabilitation programs, including education, training and corporate support, as well as a typical emphasis in larger chains to focus on Medicare admissions.

- Statewide, the Occupancy percentage for all SNFs is 86.4%; the Occupancy percentage for chains having 10 or more facilities is 84.7%.

- Statewide, the Medicare percentage for all SNFs is 10.0%, the Medicare percentage for chains having 10 or more facilities is 12.3%.

- Statewide, the Medi-Cal percentage for all SNFs is 66.6%; the Medi-Cal percentage for chains having 10 or more facilities is 66.9%.

- Statewide, the Private Pay percentage for all SNFs is 15.0%; the Private Pay percentage for chains having 10 or more facilities is 12.3%.

- Statewide, the Managed Care/Other percentage for all SNFs is 8.5%; the Occupancy percentage for chains having 10 or more facilities is 8.5%.

Overall occupancy for chains of ten or more is 4.2% lower than chains with three to nine facilities. Larger chains may have acquired facilities in weaker markets as part of the acquisitions of groups of facilities as one reason for this overall occupancy variance. In addition, Senior Consulting's knowledge of several of the large chains and their particular facilities, including site visits, indicates that there is a higher census in facilities owned by larger chains in urban areas versus rural areas, particularly in Los Angeles County.

Conclusions Chains of Ten or More

There are variances in census and payor mix for larger chains for a variety of reasons. Two chains that have publicized issues with compliance with DHS regulations have below average occupancy and payor mix. Some chains have more facilities in certain

regions of the state, and as referenced herein, there are regional variances. Senior Consulting is familiar with many buildings owned by several chains, and there is also a variance in management's commitment to "curl appeal," maintaining the physical plant, decorating and upgrading furnishings in common areas at a minimum. There are variances in the income demographics in locations of facilities by chains across the state.

Discussions with many operators also indicate that management's commitment to resources to improve occupancy and payor mix vary substantially, even though slight percentages in improvement in Medicare and Private Pay patients, and Managed Care to a lesser extent when compared to MediCal can result in millions of dollars in increased profits for operators of many facilities.

Summary of Variances in Occupancy and Payor Mix Statewide

Following are two charts that demonstrate variances in occupancy for facilities that are owned by operators that own one or two facilities, small chains that own between three and nine facilities, and chains that own ten or more facilities. Since facilities that contain residential care beds in addition to SNF beds, often target Private Pay occupancy and/or short-term rehabilitation in their SNF beds or have a primary focus on residential care beds, data including SNFs that have residential beds is included in the first chart below. In comparing variances for SNF ownership statewide, as well as on a regional basis to follow, the most valuable data is in the second chart below which compares SNFs owned and operated by entities that do not include residential care beds.

Occupancy Data Including Facilities with Licensed SNF and Residential Beds:

# of Facilities	Occup.	Medicare	Medi-Cal	Private Pay	HMO/Other
Statewide (1)	86.4%	10.0%	66.6%	15.0%	8.5%
1 or 2	87.0%	9.0%	67.6%	15.6%	7.7%
3 to 9	88.9%	8.4%	61.5%	18.0%	12.1%
10 or more	84.7%	12.3%	66.9%	12.3%	8.5%

Occupancy Data Excluding Facilities with Licensed SNF and Residential Beds:

# of Facilities	Occup.	Medicare	Medi-Cal	Private Pay	HMO/Other
Statewide (2)	86.4%	10.0%	69.2%	12.5%	8.3%
1 or 2	87.2%	9.1%	70.8%	12.6%	7.5%
3 to 9	88.5%	8.2%	67.2%	13.1%	11.5%
10 or more	84.6%	12.2%	67.1%	12.2%	8.4%

(1) Includes 1,134 SNFs in California that reported financial data to OSHPD.

(2) Includes 990 SNFs in California that reported financial data to OSHPD and did not have licensed Residential beds.

Conclusions/Statewide Data and Payor Mix Analysis:

Larger chains have by far the highest percentage of Medicare admissions, while chains of three to nine have substantially higher percentage of Private Pay and HMO/Other patients, yet lower Medicare census. Larger chains have more resources, including depth of management staff and increased educational training resources, as a contributing factor in the higher Medicare census. Chains of 3-9 facilities with the lowest Medicare census clearly demonstrate an opportunity for improvement and a need for strategic planning and professional guidance. Chains of 3-9 facilities also have the highest HMO/Other Census of the groupings. Facilities with two or less owned by the same group or corporate entity have the highest Medi-Cal Census and the lowest HMO/Other Census.

Regional Occupancy and Payor Mix Variances

While there is a fairly substantial variance in certain payor types for different types of skilled care facility ownership, i.e. sole proprietors, small chains or large chains, there is very substantial variances in payor mix of the regions analyzed in the state of California. Senior Consulting has completed a detailed analysis of all facilities, by occupancy percentage and payor type, in the following Counties to date: Los Angeles, Orange, Sacramento, Alameda and Contra Costa.

In addition, payor mix and census has been reviewed for all facilities in the following additional Counties: Riverside, Marin, San Francisco, San Mateo, Santa Clara, Monterey, Sonoma, Solano and San Joaquin Counties. In all instances, there were extreme variances in all payor mix categories except Medi-Cal and substantial occupancy variances.

There are typically varied income demographics within a County as a common reason for variances in payor mix. However, the differences in the approaches of management, including insufficient commitment of resources to marketing and in upgrading the physical plants, relative to comparable commitments of other operators in their service area are also typical contributing factors to substantial variances.

While we compared variances in many Counties statewide, we found that these substantial and extreme variances were typical in all of the Counties we reviewed. Therefore, we did not include comparative analysis for all of the Counties. Following is census data for Los Angeles County, which includes comparisons to statewide data:

Los Angeles County – SNFs & SNF/RES

- In Los Angeles County, the Occupancy percentage for all SNFs is 87.8%, comparable with statewide occupancy of 86.4%, but lower than most Bay area Counties.

- In Los Angeles County, the Medicare Occupancy percentage for all SNFs is 9.6%, slightly below the statewide average.

- In Los Angeles County, the Medi-Cal percentage for all SNFs is 71.1%, higher than the statewide average of 66.6%.

- In Los Angeles County, the Private Pay percentage for all SNFs is 11.6%, well below a statewide average of 15%.

- In Los Angeles County, the Managed Care/Other percentage for all SNFs is 7.6%, below the statewide average of 8.5%.

Alameda County – SNFs Only

- In Alameda County, the Occupancy percentage for SNFs only is 89.1%, higher than the statewide average of 86.4%. Four SNFs have an Occupancy percentage of less than 80%; yet four SNFs have a percentage of greater than 97%.

- Seventeen of 57 SNFs have a Medicare census of 10% or higher, ranging from 10.0% to 19.6%, yet twenty six of 57 SNFs have a Medicare census of 5% or less, ranging from 0.0% to 5.0%. The Medicare census for the remaining 40 SNFs, excluding the 17 referenced facilities, is 4.3%. There is an extreme variance throughout the County.

- Five of 57 SNFs have a Private Pay census of 40% or higher, ranging from 45% to 100%. Nineteen of 57 SNFs have a Private Pay census of 15% or higher, ranging from 15% to 100%. Twenty-three of 57 SNFs have a Private Pay census of 8% or less, ranging from 0.0% to 8.0%. The Private Pay census for the remaining 38 SNFs, excluding the 19 referenced facilities, is 6.6%. The Private Pay census for the remaining 52 SNFs, excluding the five referenced facilities, is 10.7%. There is an extreme variance through out the County private pay census.

- Six of 57 SNFs have a Managed Care & Other census of 10% or higher, ranging from 10.1% to 40.7%. The Managed Care & Other census for the remaining 51 SNFs, excluding the six referenced facilities, is 2.7%.

The following chart compares the wide variance in Medicare Census in five counties:

County	# of SNFs, Occ. %	Medicare %	Low Medicare	High Medicare
Alameda	(57) 89.1%	7.3%	(26) 0.0 - 5%	(17) 10.0 - 19.6%
Contra Costa	(31) 85.5%	11%	(5) 0.0 - 5%	(16) 10.0 - 29.8%
Los Angeles	(324) 87.5%	9.8%	(83) 0.0 - 5%	(130) 10.0 - 82.4%
Orange	(58) 80.0%	12.8%	(6) 0.0 - 5%	(37) 10.0 - 37.4%
Sacramento	(32) 89.9%	7.7%	(11) 0.0 - 5%	(7) 10.0 - 23.7%

The following chart compares the wide variance in Private Pay Census in five counties:

County	# of SNFs, Occ. %	Private %	Low Private	High Private
Alameda	(57) 89.1%	14.4%	(16) 0.0 - 5%	(18) 15.0 - 100.0%
Contra Costa	(31) 85.5%	20.7%	(26) 0.0 - 5%	(17) 15.0 - 19.6%
Los Angeles	(324) 87.5%	9.1%	(142) 0.0 - 5%	(66) 15.0 - 100.0%
Orange	(58) 80.0%	12.6%	(13) 0.0 - 5%	(13) 15.0 - 100.0%
Sacramento	(32) 89.9%	14.7%	(6) 0.0 - 5%	(12) 15.0 - 81.2%

Regional Conclusions

Private Pay and Medicare census have extreme variances, as demonstrated herein in the above charts for five California counties in regions throughout the State of California. Occupancy and Managed Care census varies by region, but not as substantially. These variances are as evident in smaller areas, such as individual hospital service areas of clients of Senior Consulting. Within the Counties as referenced in this report and in our expanded due diligence on behalf of various clients, it is also clear there are very substantial payor mix and occupancy differences within defined service areas of acute hospitals. Clearly, the philosophy and commitment of management in both admitting higher acuity patients and improving their physical plants varies substantially within the defined market areas for these skilled care operators.

General Conclusions

While there are clearly opportunities for many operators statewide to improve occupancy and payor mix, the greatest opportunity is in selected markets. Opportunities for all types of operators should include a commitment of sufficient resources to marketing and census development, including market analysis and strategic planning. Operators need to be open to expanding existing directives and make new efforts to improve census and payor mix through traditional and non-traditional means, which includes efforts to expand and alter relationships with Hospitals in their service area.

Exhibit B

Analysis of Individual Patients, by LOS Grouping for Medicare Transfer DRGs

Exhibit B
Financial Analysis

Sample Hospital - Medicare Transfer Discharges Sorted Net Profit/Loss (1)

Patient Number	DRG Number (2)	Relative Weight (3)	Payer LOS (4)	Actual LOS (5)	Limit Reimb. (6)	Final Reimb. (7)	Expenses (8)	Net Profit/ Loss (9)
		Patients with Actual LOS exceeding Payer LOS by 20% or more						
1	209	2.0332	4.3	21.0	$17,569	$17,569	$46,724	($29,155)
2	531	3.096	6.5	30.0	$26,807	$26,807	$66,749	($39,942)
3	120	2.3051	5.6	14.0	$19,918	$19,918	$31,149	($11,231)
4	395	0.8399	3.2	8.0	$7,259	$7,259	$17,800	($10,541)
5	475	3.6166	8.0	19.0	$31,251	$31,251	$42,274	($11,023)
6	508	1.3358	5.1	12.0	$11,552	$11,552	$26,699	($15,147)
7	14	1.2719	4.8	11.0	$10,990	$10,990	$24,474	($13,484)
8	217	2.9339	9.0	20.0	$25,352	$25,352	$44,499	($19,147)
9	218	1.5762	4.3	9.0	$13,620	$13,620	$20,025	($6,405)
10	287	1.909	7.5	14.0	$16,496	$16,496	$31,149	($14,653)
11	107	5.3767	9.3	17.0	$46,451	$46,451	$37,824	$8,627
12	141	0.7617	2.8	5.0	$6,586	$6,586	$11,125	($4,539)
13	418	1.0726	4.8	7.0	$9,269	$9,269	$15,575	($6,306)
14	87	1.3542	4.9	7.0	$11,715	$11,715	$15,575	($3,860)
15	296	0.842	3.8	5.0	$7,276	$7,276	$11,125	($3,849)
16	23	0.8365	3.2	4.0	$7,232	$7,232	$8,900	($1,668)
17	239	1.0811	5.0	6.0	$9,342	$9,342	$13,350	($4,008)
(Note A)			5.4	12.3	$278,685	$278,685	$465,015	($186,330)
		Patients with Actual LOS not exceeding Payer LOS by 20% or more						
18	180	0.9753	4.2	5.0	$8,428	$8,428	$11,125	($2,697)
19	20	2.8318	8.0	9.0	$24,470	$24,470	$20,025	$4,445
20	130	0.9566	4.5	5.0	$8,266	$8,266	$11,125	($2,859)
21	416	1.5882	5.5	6.0	$13,810	$13,810	$13,350	$460
22	416	1.5982	5.5	6.0	$13,810	$13,810	$13,350	$460
23	239	1.0811	5.0	5.0	$9,352	$9,352	$11,125	($1,773)
24	127	1.039	4.1	4.0	$8,978	$8,759	$8,900	($141)
25	320	0.8776	4.3	4.0	$7,583	$7,054	$8,900	($1,846)
26	14	1.2719	4.6	4.0	$10,990	$9,557	$8,900	$657
27	14	1.2719	4.6	4.0	$11,084	$9,569	$8,900	$669
28	541	20.0414	38.7	33.0	$173,178	$147,671	$73,423	$74,248
29	89	1.0479	4.8	4.0	$9,055	$7,546	$8,900	($1,354)
30	87	1.3542	4.9	4.0	$11,702	$9,562	$8,900	$662
31	239	1.0811	5.0	4.0	$9,342	$7,473	$8,900	($1,427)
32	79	1.5872	6.6	5.0	$13,715	$10,390	$11,125	($735)
33	121	1.62	5.3	4.0	$13,998	$10,565	$8,900	$1,665
34	88	0.9089	4.1	3.0	$7,854	$5,747	$6,675	($928)
35	127	1.039	4.1	3.0	$8,983	$6,573	$6,675	($102)
36	416	1.5982	5.5	4.0	$13,810	$13,810	$8,900	$4,910
37	150	2.7469	6.9	5.0	$23,761	$13,349	$11,125	$2,224
38	180	0.9753	4.2	3.0	$8,428	$6,020	$6,675	($655)
39	148	3.3871	10.0	7.0	$29,268	$20,488	$15,575	$4,913
40	209	2.0332	4.3	3.0	$17,569	$16,956	$6,675	$10,281
41	83	0.9806	4.3	3.0	$8,473	$5,912	$6,675	($763)
42	210	1.8817	6.1	4.0	$16,260	$16,126	$8,900	$7,226
43	14	1.2719	4.6	3.0	$10,990	$7,168	$6,675	$493
44	14	1.2719	4.8	3.0	$10,990	$6,869	$6,675	$194
45	243	0.7712	3.7	2.0	$6,664	$3,602	$4,450	($848)
46	277	0.8677	4.7	2.0	$7,678	$3,267	$4,450	($1,183)
47	89	1.0479	4.8	2.0	$9,055	$3,773	$4,450	($677)
48	236	0.7544	3.9	1.0	$6,519	$1,671	$2,225	($554)
49	12	0.9136	4.3	1.0	$7,894	$1,836	$2,225	($389)
50	89	1.0479	4.8	1.0	$9,055	$1,886	$2,225	($339)
(Note B)			6.1	4.7	$551,012	$441,335	$347,092	$94,243

Exhibit B
Financial Analysis

NOTES Sample Hospital - Medicare Transfer Discharges Sorted Net Profit/Loss

1 Based on data contained in a spreadsheet for September, 2005 prepared by Controller of a Hospital with an average daily census of 104 patients for 2004 for a hospital that has a substantial amount of charity care. This data was not in the IT system, and was entered manually from data supplied by HIM. There are two subsections in Senior Consulting's Analysis, the first is for patients with an Actual LOS that is at least 20% higher than the Payer LOS as designated by CMS. The second grouping is for patients that are less than 20% higher than the Payer LOS or have a Actual LOS less than the Payer LOS.

2 Each patient admitted to the Hospital is designated as one of the Diagnosis-Related Groups (DRGs) Only the Transfer Discharges are included herein.

3 Each DRG is assigned a specific Relative Weight by the Centers for Medicare & Medicaid Services (CMS).

4 The numbers of days the average patient with this DRG remains in the Hospital.

5 The actual number of days the patient remained in the Hospital.

6 The maximum reimbursement from Medicare for caring for a patient with this DRG.

7 The actual reimbursement received by the Hospital.

8 Based on data obtained from the OSHPD Web site, the annual Operating Expenses for the Hospital in 2004 were $140,620,703.00. The total number of Patient Days was 37,921. Therefore, the average Daily Operating Expenses per Patient is $3,708.25. The average Daily Operating Expenses per Patient is multiplied by the days of Actual LOS to determine the total expenses associated with the patient's stay, minus an estimated 40% for expenses including charity care and ancillary services.

9 Represents estimated Net Profit/Loss on per patient basis, versus typical averaging by groups of patients or overall.

Note A
* The average for Payer LOS for this grouping of patients is 5.4.
* The average for Actual LOS of patients for this grouping is 12.3.
* The total Limit on Reimbursement for this grouping of patients is $278,685.
* The total Final Reimbursement for this grouping of patients is $278,685.
* The total Net Loss on this grouping of patients is $186,330.

Note B
* The average for Payer LOS for this grouping of patients is 6.1.
* The average for Actual LOS of patients for this grouping is 4.7.
* The total Limit on Reimbursement for this grouping of patients is $551,012.
* The total Final Reimbursement for this grouping of patients is $441,335.
* The total Net Profit on this grouping of patients is $94,243.

Conclusion: Using targeted Post Acute Discharge strategies based on individual patient diagnoses and negotiations, a 50% reduction in Actual LOS for 17 of 50 patients would have resulting in savings of $93,165 to the Hospital for the month and $1,017,980 annually.

Exhibit C

Northern California Transfer Discharges Analysis

Exhibit C

Northern California - Medicare Transfer Discharges

Hospital	City	Type of Governance (1)	LTC Occup. (2)	Number of Beds	Overall Occupancy (3)	Total Medicare Discharge % (4)	Medicare Discharges (5)	Total Discharges (6)
Northern California (12)								
Alameda County Medical Center	Oakland	City/County	N	453	68.4%	9.5%	1,361	14,363
Contra Costa Regional Medical Center	Martinez	City/County	N	164	74.0%	16.7%	1,599	9,556
Natividad Medical Center	Salinas	City/County	N	136	61.2%	10.8%	866	8,009
			Totals (12)	753	67.9%	12.3%	3,826	31,928
Doctors Medical Center	San Pablo	District	N	239	43.4%	46.6%	3,523	7,556
El Camino Hospital	Mountain View	District	Y, <80%	320	72.7%	34.6%	6,008	17,352
Hazel Hawkins Memorial Hospital	Hollister	District	Y, >80%	154	80.4%	32.4%	908	2,800
Salinas Valley Memorial Hospital	Salinas	District	N	222	70.4%	39.6%	5,126	12,954
Washington Hospital	Fremont	District	N	311	58.8%	37.9%	5,927	15,655
			Totals (12)	1,246	65.1%	38.2%	21,492	56,317
Community Hosp. of Monterey	Monterey	Nonprofit	N	173	83.6%	44.2%	5,494	12,427
John Muir Med. Center	Walnut Creek	Nonprofit	N	322	77.3%	35.7%	6,421	18,001
Marin General Hosp.	Greenbrae	Nonprofit	N	150	79.3%	39.9%	4,372	10,955
Mt. Diablo Med. Center	Concord	Nonprofit	N	254	52.3%	55.3%	5,254	9,502
Queen of The Valley Hospital	Napa	Nonprofit	Y, <80%	179	67.4%	49.5%	3,991	8,062
Santa Rosa Memorial Hospital	Santa Rosa	Nonprofit	N	346	64.1%	44.6%	6,455	14,472
Seton Medical Center	Daly City	Nonprofit	Y, >80%	279	82.0%	57.5%	5,641	9,817
St. Lukes Hospital	San Francisco	Nonprofit	Y, >80%	207	69.1%	37.8%	2,374	6,274
Valley Memorial Hosp.	Livermore	Nonprofit	Y, <80%	170	67.4%	39.3%	3,087	7,852
			Totals (12)	2,080	71.4%	44.9%	43,089	97,362
			Regional Totals	4,079	68.9%	37.2%	68,407	185,607

Hospital		Transfer DRGs (7)	Subtotal Transfer DRGs (8)	Top 25 DRGs as % of Total Transfer Discharge DRGs (8)	Total Transfer Discharge DRGs (9)	Expenses per Patient Day (10)	Proj. Loss for Medicare LOS
Northern California (12)							
Alameda County Medical Center		35	5,105	63.5%	8,043	$2,939.85	$228,544.88
Contra Costa Regional Medical Center		30	2,161	40.4%	5,351	$6,074.70	$554,832.00
Natividad Medical Center		20	1,109	24.7%	4,485	$3,494.62	$172,864.59
	Totals (12)	28.3	8,375	42.9%	17,880	$4,169.72	$318,747.16
Doctors Medical Center		28	2,166	51.2%	4,231	$3,708.25	$746,225.09
El Camino Hospital		28	2,273	23.4%	9,717	$3,730.64	$640,134.85
Hazel Hawkins Memorial Hospital		29	640	40.8%	1,568	$1,192.22	$30,917.22
Salinas Valley Memorial Hospital		23	1,337	18.4%	7,254	$4,289.08	$1,255,830.27
Washington Hospital		24	1,805	20.6%	8,767	$3,462.02	$1,172,067.70
	Totals (12)	26.4	8,373	30.9%	31,538	$3,276.44	$769,035.03
Community Hosp. of Monterey		22	2,179	31.3%	6,959	$4,977.75	$1,562,103.97
John Muir Med. Center		24	2,473	24.5%	10,081	$4,226.13	$1,550,007.22
Marin General Hosp.		24	1,861	30.3%	6,135	$5,204.20	$1,299,637.79
Mt. Diablo Med. Center		29	2,155	40.5%	5,321	$4,307.92	$1,292,843.32
Queen of The Valley Hospital		25	1,713	37.9%	4,515	$3,622.01	$412,847.42
Santa Rosa Memorial Hospital		25	3,464	42.7%	8,104	$2,883.93	$1,063,332.68
Seton Medical Center		28	2,596	47.2%	5,498	$2,536.15	$408,591.42
St. Lukes Hospital		23	1,640	46.7%	3,513	$2,330.89	$158,037.70
Valley Memorial Hosp.		29	2,201	50.1%	4,397	$3,990.78	$351,846.00
	Totals (12)	25.4	20,282	39.0%	54,523	$3,786.64	$899,916.39
	Regional Totals	26.2	37,030	37.3%	103,940	$3,704.18	$758,862.59

Notes: Northern California Discharge Summary

1 All District and Government owned hospitals having between 100 and 499 available versus licensed beds are included in this Analysis. There are five hospitals having between 500 and 579 beds, LAC-USC (916 beds), and Laguna Honda (1,147 beds) not included. None of the hospitals owned by Nonprofit chains that operate 1,000 or more beds or 5 hospitals are included in this Analysis except for Marin General Hospital, St. Lukes, Queen of the Valley Hospital, and Valley Memorial Hospital which are included for geographic and demographic balance. One rural District Hospital, Mayers Memorial Hospital, was not included in this Analysis because of apparent anomalies in the data reported to OSHPD.

2 These symbols have the following definitions: Y, >80% - The occupancy rate for the hospital's LTC beds is in excess of 80%; Y, <80% - The occupancy rate for the hospital's LTC beds is less than 80%; N - The hospital does not have LTC beds.

3 Stated averages for Overall Occupancy and Medicare Discharge % are not weighted based on the number of beds at each hospital.

4 The total Medicare Discharges for 2004 divided by Total Discharges.

5 Annual total Medicare Discharges for 2004 as reported to OSHPD.

6 Annual total Discharges for 2004 as reported to OSHPD.

7 The number of Transfer DRGs within the Top 25 DRGs for each of the following categories: Number of Discharges, Average Length of Stay, and Average Charge Per Stay.

8 The number of transfer discharges assigned from the Transfer DRGs within the Top 25 DRGs for each of the following categories: Number of Discharges, Average Length of Stay, and Average Charge Per Stay. The Subtotal of Transfer DRGs within the Top 25 DRGs as a percentage of overall Total Transfer Discharge DRGs.

9 Represents the Transfer DRGs within the Top 25 DRGs for each of the following categories: Number of Discharges, Average Length of Stay, and Average Charge Per Stay plus the number of discharges in the remaining Transfer DRGS based on 56% of the Total Discharges being assigned a Transfer DRG code. The 56% assumption is based on an independent report dated February 22, 2006, which analyzed all DRGs assigned to discharged Medicare patients for 2,988 hospitals nationwide.

10 Total Operating Expenses divided by Total Patient Days as reported to OSHPD.

11 The Projected Loss is based on an Analysis of a client's experience entitled Acute Medicare Transfer Discharges Analysis. Specifically, in this separate, but related Analysis, patients that were Medicare Transfer Discharges were individually placed in two separate groupings, those that exceeded the target reimbursable LOS by Medicare by 20% or more and those that were transferred sooner than that. Our focus is the 34% of the patients in the group that exceeded the targeted LOS by 20% or more. We assume that half of those patients were not clinically appropriate for discharge to a post-acute setting. We assume there are not one or more SNFs in the hospital service area with staff trained in the care of higher acuity patients, management and vendor support such as Pharmacy, such as the operating and clinical criteria of admissions to a licensing Medi-Cal Subacute unit, but that a relationship with a SNF in the service area could be established. Utilizing the Expenses PPD for each hospital derived from OSHPD data, we applied that PPD for an average of one day in excess of the Average Length of Stay of each patient's DRG code, minus an estimated 40% for expenses including charity care and ancillary services, to 56% of the total Medicare Discharges of each hospital herein, with 50% of hospital herein, with 50% of that total for those Hospitals that do not operate a SNF and only 25% for those that do operate a SNF. With higher wages for hospitals compared to freestanding SNFs, Medicare patients as well as Medi-Cal, if applicable, it would be more fiscally prudent to place patients in an alternative setting other than the Hospital's LTC facility.

12 There is substantial fluctuation in Medicare Discharges as a percentage of Total Discharges, with the only three Northern California County Hospitals with between 100-499 beds having only 9.5%, 10.8% and 16.7% of Total Discharges being Medicare Discharges. For the five District Hospitals in Northern California, Medicare Discharges as a percentage of Total Discharges ranged from 32.4% to 46.6%, a non-weighted average of 38.2%. We assessed 9 of the 14 Nonprofit hospitals in Northern California with at least 100 beds, not including large organizations operating at least five hospitals or 1,000 beds. For Nonprofit Hospitals in Northern California, Medicare Discharges as a percentage of Total Discharges ranged from 35.7% to 57.5%, a non-weighted average of 44.9%.

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
430	PSYCHOSES	7,937	7,922	$22,777	8.4	9
127	HEART FAILURE &SHOCK	4,429	4,428	$34,143	4.9	16
462	REHABILITATION	3,468	3,467	$43,770	15.3	10
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	3,366	3,366	$32,410	5.1	15
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	1,868	1,867	$46,466	11.8	16
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1,742	1,742	$44,137	5.8	12
416	SEPTICEMIA AGE >17	1,544	1,543	$55,997	7.0	11
79	RESP INFECTN AGE >17 W CC	1,021	1,021	$52,115	8.0	8
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	966	966	$122,739	12.2	11
475	RESPIRATORY SYS DIAG W VENTILATOR SUPPORT	838	838	$167,954	21.0	12
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	766	766	$30,507	5.0	6
277	CELLULITIS AGE >17 W CC	729	729	$19,918	5.2	6
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	442	442	$146,389	16.1	12
1	CRANIOTOMY AGE >17 W CC	391	391	$131,909	12.0	9
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	322	322	$137,961	14.7	9
294	DIABETES AGE >35	310	310	$30,971	3.9	3
316	RENAL FAILURE	306	306	$55,101	7.6	3
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	296	296	$28,890	11.5	2
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	268	268	$83,491	8.0	2
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	233	233	$214,814	10.2	9
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	223	223	$156,570	18.5	11
497	SPINAL FUSION EXCEPT CERVICAL W CC	219	219	$126,349	7.1	6
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	187	187	$128,115	12.2	10
263	SKIN GRAFT DEBRID SKN ULCR/CELLITIS W CC	177	177	$196,890	47.7	7
278	CELLULITIS AGE >17 W/O CC	177	176	$10,082	3.1	2
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	160	160	$137,148	19.1	12
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	153	153	$247,559	39.1	7
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	151	151	$265,332	14.1	9
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	149	143	$379,499	135.7	6
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	100	100	$111,514	4.0	2
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	90	90	$160,975	13.3	2
174	G.I. HEMORRHAGE W CC	87	86	$41,826	4.9	1
522	ALC/DRG ABUSE/ DEPEND W REHAB THERAPY W/O CC	87	87	$29,586	9.6	1
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	84	84	$193,373	18.7	14
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	78	78	$67,127	6.4	1
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	65	63	$909,952	216.2	3
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	65	65	$174,549	16.0	6
108	OTHER CARDIOTHORACIC PROCEDURES	63	63	$232,669	10.5	8
271	SKIN ULCERS	60	60	$31,255	16.7	4
150	PERITONEAL ADHESIOLYSIS W CC	59	59	$113,256	15.3	7
75	MAJOR CHEST PROCEDURES	54	54	$114,624	15.3	5
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	42	42	$152,128	20.9	8
126	ACUTE & SUBACUTE ENDOCARDITIS	38	38	$94,405	15.1	5
292	OTHR ENDOCRINE NUTRIT/METAB O.R. PROC W CC	38	38	$103,127	14.4	4
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	37	37	$124,531	13.1	3
7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	35	35	$306,448	231.9	4
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	35	31	$11,317	39.9	2
285	AMPUT LWR LMB ENDOCRN NUTRIT/METABOL DIS	32	32	$193,142	22.4	8
238	OSTEOMYELITIS	29	29	$62,509	18.1	4
240	CONNECTIVE TISSUE DISORDERS W CC	28	27	$113,322	22.6	2
146	RECTAL RESECTION W CC	25	25	$112,988	14.3	5
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	25	25	$155,321	15.3	3
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	23	23	$147,256	23.8	5
10	NERVOUS SYSTEM NEOPLASMS W CC	22	21	$33,414	127.0	1
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	21	21	$139,341	16.1	1
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	20	20	$100,374	13.9	4
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	16	16	$137,429	19.5	5
287	SKIN GRFT/WND DEBRID ENDOC NUTRIT/METAB	16	16	$141,872	17.7	4
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	16	16	$133,157	13.8	4

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197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	15	15	$165,156	13.6	3
172	DIGESTIVE MALIGNANCY W CC	13	13	$51,882	17.0	2
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	13	13	$48,721	17.1	2
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	12	12	$86,027	30.8	1
272	MAJOR SKIN DISORDERS W CC	10	10	$139,526	16.9	2
144	OTHER CIRCULATORY SYSTEM DIAG W CC	7	7	$33,887	7.7	1
226	SOFT TISSUE PROCEDURES W CC	7	7	$102,330	19.0	2
265	SKIN GRFT DEBRID EX SKN ULCER/CELL W CC	7	7	$72,445	18.2	2
280	TRAUMA SKIN SUBCUT TIS/BREAST AGE 0-17	7	7	$63,254	30.9	1
440	WOUND DEBRIDEMENTS FOR INJURIES	7	7	$88,380	15.7	2
131	PERIPHERAL VASCULAR DISORDERS W/O CC	6	6	$7,975	7.5	1
264	SKIN GRAFT DEBRID SKN ULCR/CELLITS WO CC	6	6	$177,102	18.2	1
501	KNEE PROCEDURES W PDX OF INFECTION W CC	6	6	$132,946	23.6	3
464	SIGNS & SYMPTOMS W/O CC	5	5	$37,022	14.2	1
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	5	5	$75,512	11.8	2
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	4	4	$91,626	33.3	1
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	4	4	$139,434	5.8	2
17	NONSPEC CEREBROVASCULAR DISORDERS W/O CC	3	3	$34,401	14.0	1
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	3	3	$118,686	25.7	1
29	TRAUMATIC STPR/COMA <1 HR AGE >17 W/O CC	3	3	$2,726,497	836.0	1
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	3	3	$68,699	14.8	2
85	PLEURAL EFFUSION W CC	3	3	$39,181	8.3	1
269	OTHR SKIN SUBCUT TISS/BREAST PROC W CC	3	3	$110,927	20.0	1
8	PERIPH/CRANL NERVE/OTHER NRV PROC W/O CC	2	2	$93,968	17.0	1
16	NONSPEC CEREBROVASCULAR DISORDERS W CC	2	2	$1,388,438	804.0	2
192	PANCREAS/LIVER/SHUT PROCEDURES W/O CC	2	2	$108,471	14.0	1
225	FOOT PROCEDURES	2	2	$106,487	20.0	1
151	PERITONEAL ADHESIOLYSIS W/O CC	1	1	$96,611	16.0	1
157	ANAL &STOMAL PROCEDURES W CC	1	1	$41,122	7.0	1
235	FRACTURES OF FEMUR	1	1	$12,106	8.0	1
283	MINOR SKIN DISORDERS W CC	1	1	$66,177	14.0	1

NOTE

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7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	35	35	$306,448	231.9	4
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	65	63	$909,952	216.2	3
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	149	143	$379,499	135.7	6
10	NERVOUS SYSTEM NEOPLASMS W CC	22	21	$33,414	127.0	1
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80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	12	12	$86,027	30.8	1
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240	CONNECTIVE TISSUE DISORDERS W CC	28	27	$113,322	22.6	2
285	AMPUT LWR LMB ENDOCRN NUTRIT/METABOL DIS	32	32	$193,142	22.4	8
475	RESPIRATORY SYS DIAG W VENTILATOR SUPPORT	838	838	$167,954	21.0	12
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	42	42	$152,128	20.9	8
269	OTHR SKIN SUBCUT TISS/BREAST PROC W CC	3	3	$110,927	20.0	1
225	FOOT PROCEDURES	2	2	$106,487	20.0	1
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	16	16	$137,429	19.5	5
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	160	160	$137,148	19.1	12
226	SOFT TISSUE PROCEDURES W CC	7	7	$102,330	19.0	2
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	84	84	$193,373	18.7	14
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	223	223	$156,570	18.5	11
264	SKIN GRAFT DEBRID SKN ULCR/CELLITS WO CC	6	6	$177,102	18.2	1
265	SKIN GRFT DEBRID EX SKN ULCER/CELL W CC	7	7	$72,445	18.2	2
238	OSTEOMYELITIS	29	29	$62,509	18.1	4
287	SKIN GRFT/WND DEBRID ENDOC NUTRIT/METAB	16	16	$141,872	17.7	4
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	13	13	$48,721	17.1	2
172	DIGESTIVE MALIGNANCY W CC	13	13	$51,882	17.0	2
8	PERIPH/CRANL NERVE/OTHER NRV PROC W/O CC	2	2	$93,968	17.0	1
272	MAJOR SKIN DISORDERS W CC	10	10	$139,526	16.9	2
271	SKIN ULCERS	60	60	$31,255	16.7	4
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	21	21	$139,341	16.1	1
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	442	442	$146,389	16.1	12
151	PERITONEAL ADHESIOLYSIS W/O CC	1	1	$96,611	16.0	1
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	65	65	$174,549	16.0	6
440	WOUND DEBRIDEMENTS FOR INJURIES	7	7	$88,380	15.7	2
75	MAJOR CHEST PROCEDURES	54	54	$114,624	15.3	5
462	REHABILITATION	3,468	3,467	$43,770	15.3	10
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	25	25	$155,321	15.3	3
150	PERITONEAL ADHESIOLYSIS W CC	59	59	$113,256	15.3	7
126	ACUTE & SUBACUTE ENDOCARDITIS	38	38	$94,405	15.1	5
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292	OTHR ENDOCRINE NUTRIT/METAB O.R. PROC W CC	38	38	$103,127	14.4	4
146	RECTAL RESECTION W CC	25	25	$112,988	14.3	5
464	SIGNS & SYMPTOMS W/O CC	5	5	$37,022	14.2	1
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	151	151	$265,332	14.1	9
17	NONSPEC CEREBROVASCULAR DISORDERS W/O CC	3	3	$34,401	14.0	1
192	PANCREAS/LIVER/SHUT PROCEDURES W/O CC	2	2	$108,471	14.0	1
283	MINOR SKIN DISORDERS W CC	1	1	$66,177	14.0	1
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	20	20	$100,374	13.9	4
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	16	16	$133,157	13.8	4
197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	15	15	$165,156	13.6	3
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	90	90	$160,975	13.3	2
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154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	187	187	$128,115	12.2	10
1	CRANIOTOMY AGE >17 W CC	391	391	$131,909	12.0	9
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	1,868	1,867	$46,466	11.8	16
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	5	5	$75,512	11.8	2
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	296	296	$28,890	11.5	2
108	OTHER CARDIOTHORACIC PROCEDURES	63	63	$232,669	10.5	8
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	233	233	$214,814	10.2	9
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170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	25	25	$155,321	15.3	3
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	42	42	$152,128	20.9	8
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	23	23	$147,256	23.8	5
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	442	442	$146,389	16.1	12
287	SKIN GRFT/WND DEBRID ENDOC NUTRIT/METAB	16	16	$141,872	17.7	4
272	MAJOR SKIN DISORDERS W CC	10	10	$139,526	16.9	2
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	4	4	$139,434	5.8	2
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	21	21	$139,341	16.1	1
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	322	322	$137,961	14.7	9
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	16	16	$137,429	19.5	5
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	160	160	$137,148	19.1	12
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	16	16	$133,157	13.8	4
501	KNEE PROCEDURES W PDX OF INFECTION W CC	6	6	$132,946	23.6	3
1	CRANIOTOMY AGE >17 W CC	391	391	$131,909	12.0	9
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	187	187	$128,115	12.2	10
497	SPINAL FUSION EXCEPT CERVICAL W CC	219	219	$126,349	7.1	6
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	37	37	$124,531	13.1	3
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	966	966	$122,739	12.2	11
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	3	3	$118,686	25.7	1
75	MAJOR CHEST PROCEDURES	54	54	$114,624	15.3	5
240	CONNECTIVE TISSUE DISORDERS W CC	28	27	$113,322	22.6	2
150	PERITONEAL ADHESIOLYSIS W CC	59	59	$113,256	15.3	7
146	RECTAL RESECTION W CC	25	25	$112,988	14.3	5
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	100	100	$111,514	4.0	2
269	OTHR SKIN SUBCUT TISS/BREAST PROC W CC	3	3	$110,927	20.0	1
192	PANCREAS/LIVER/SHUT PROCEDURES W/O CC	2	2	$108,471	14.0	1
225	FOOT PROCEDURES	2	2	$106,487	20.0	1
292	OTHR ENDOCRINE NUTRIT/METAB O.R. PROC W CC	38	38	$103,127	14.4	4
226	SOFT TISSUE PROCEDURES W CC	7	7	$102,330	19.0	2
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	20	20	$100,374	13.9	4
151	PERITONEAL ADHESIOLYSIS W/O CC	1	1	$96,611	16.0	1
126	ACUTE & SUBACUTE ENDOCARDITIS	38	38	$94,405	15.1	5
8	PERIPH/CRANL NERVE/OTHER NRV PROC W/O CC	2	2	$93,968	17.0	1
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	4	4	$91,626	33.3	1
440	WOUND DEBRIDEMENTS FOR INJURIES	7	7	$88,380	15.7	2
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	12	12	$86,027	30.8	1
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	268	268	$83,491	8.0	2
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	5	5	$75,512	11.8	2
265	SKIN GRFT DEBRID EX SKN ULCER/CELL W CC	7	7	$72,445	18.2	2
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	3	3	$68,699	14.8	2
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	78	78	$67,127	6.4	1

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
283	MINOR SKIN DISORDERS W CC	1	1	$66,177	14.0	1
280	TRAUMA SKIN SUBCUT TIS/BREAST AGE 0-17	7	7	$63,254	30.9	1
238	OSTEOMYELITIS	29	29	$62,509	18.1	4
416	SEPTICEMIA AGE >17	1,544	1,543	$55,997	7.0	11
316	RENAL FAILURE	306	306	$55,101	7.6	3
79	RESP INFECTN AGE >17 W CC	1,021	1,021	$52,115	8.0	8
172	DIGESTIVE MALIGNANCY W CC	13	13	$51,882	17.0	2
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	13	13	$48,721	17.1	2
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	1,868	1,867	$46,466	11.8	16
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1,742	1,742	$44,137	5.8	12
462	REHABILITATION	3,468	3,467	$43,770	15.3	10
174	G.I. HEMORRHAGE W CC	87	86	$41,826	4.9	1
157	ANAL &STOMAL PROCEDURES W CC	1	1	$41,122	7.0	1
85	PLEURAL EFFUSION W CC	3	3	$39,181	8.3	1
464	SIGNS & SYMPTOMS W/O CC	5	5	$37,022	14.2	1
17	NONSPEC CEREBROVASCULAR DISORDERS W/O CC	3	3	$34,401	14.0	1
127	HEART FAILURE &SHOCK	4,429	4,428	$34,143	4.9	16
144	OTHER CIRCULATORY SYSTEM DIAG W CC	7	7	$33,887	7.7	1
10	NERVOUS SYSTEM NEOPLASMS W CC	22	21	$33,414	127.0	1
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	3,366	3,366	$32,410	5.1	15
271	SKIN ULCERS	60	60	$31,255	16.7	4
294	DIABETES AGE >35	310	310	$30,971	3.9	3
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	766	766	$30,507	5.0	6
522	ALC/DRG ABUSE/ DEPEND W REHAB THERAPY W/O CC	87	87	$29,586	9.6	1
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	296	296	$28,890	11.5	2
430	PSYCHOSES	7,937	7,922	$22,777	8.4	9
277	CELLULITIS AGE >17 W CC	729	729	$19,918	5.2	6
235	FRACTURES OF FEMUR	1	1	$12,106	8.0	1
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	35	31	$11,317	39.9	2
278	CELLULITIS AGE >17 W/O CC	177	176	$10,082	3.1	2
131	PERIPHERAL VASCULAR DISORDERS W/O CC	6	6	$7,975	7.5	1

NOTE

See other supporting information summarizing 17 Northern California Hospitals.

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
127	HEART FAILURE &SHOCK	4,429	4,428	$34,143	4.9	16
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	1,868	1,867	$46,466	11.8	16
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	3,366	3,366	$32,410	5.1	15
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	84	84	$193,373	18.7	14
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1,742	1,742	$44,137	5.8	12
475	RESPIRATORY SYS DIAG W VENTILATOR SUPPORT	838	838	$167,954	21.0	12
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	442	442	$146,389	16.1	12
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	160	160	$137,148	19.1	12
416	SEPTICEMIA AGE >17	1,544	1,543	$55,997	7.0	11
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	966	966	$122,739	12.2	11
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	223	223	$156,570	18.5	11
462	REHABILITATION	3,468	3,467	$43,770	15.3	10
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	187	187	$128,115	12.2	10
430	PSYCHOSES	7,937	7,922	$22,777	8.4	9
1	CRANIOTOMY AGE >17 W CC	391	391	$131,909	12.0	9
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	322	322	$137,961	14.7	9
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	233	233	$214,814	10.2	9
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	151	151	$265,332	14.1	9
79	RESP INFECTN AGE >17 W CC	1,021	1,021	$52,115	8.0	8
108	OTHER CARDIOTHORACIC PROCEDURES	63	63	$232,669	10.5	8
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	42	42	$152,128	20.9	8
285	AMPUT LWR LMB ENDOCRN NUTRIT/METABOL DIS	32	32	$193,142	22.4	8
263	SKIN GRAFT DEBRID SKN ULCR/CELLITIS W CC	177	177	$196,890	47.7	7
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	153	153	$247,559	39.1	7
150	PERITONEAL ADHESIOLYSIS W CC	59	59	$113,256	15.3	7
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	766	766	$30,507	5.0	6
277	CELLULITIS AGE >17 W CC	729	729	$19,918	5.2	6
497	SPINAL FUSION EXCEPT CERVICAL W CC	219	219	$126,349	7.1	6
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	149	143	$379,499	135.7	6
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	65	65	$174,549	16.0	6
75	MAJOR CHEST PROCEDURES	54	54	$114,624	15.3	5
126	ACUTE & SUBACUTE ENDOCARDITIS	38	38	$94,405	15.1	5
146	RECTAL RESECTION W CC	25	25	$112,988	14.3	5
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	23	23	$147,256	23.8	5
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	16	16	$137,429	19.5	5
271	SKIN ULCERS	60	60	$31,255	16.7	4
292	OTHR ENDOCRINE NUTRIT/METAB O.R. PROC W CC	38	38	$103,127	14.4	4
7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	35	35	$306,448	231.9	4
238	OSTEOMYELITIS	29	29	$62,509	18.1	4
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	20	20	$100,374	13.9	4
287	SKIN GRFT/WND DEBRID ENDOC NUTRIT/METAB	16	16	$141,872	17.7	4
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	16	16	$133,157	13.8	4
294	DIABETES AGE >35	310	310	$30,971	3.9	3
316	RENAL FAILURE	306	306	$55,101	7.6	3
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	65	63	$909,952	216.2	3
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	37	37	$124,531	13.1	3
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	25	25	$155,321	15.3	3
197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	15	15	$165,156	13.6	3
501	KNEE PROCEDURES W PDX OF INFECTION W CC	6	6	$132,946	23.6	3
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	296	296	$28,890	11.5	2
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	268	268	$83,491	8.0	2
278	CELLULITIS AGE >17 W/O CC	177	176	$10,082	3.1	2
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	100	100	$111,514	4.0	2
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	90	90	$160,975	13.3	2
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	35	31	$11,317	39.9	2
240	CONNECTIVE TISSUE DISORDERS W CC	28	27	$113,322	22.6	2
172	DIGESTIVE MALIGNANCY W CC	13	13	$51,882	17.0	2
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	13	13	$48,721	17.1	2
272	MAJOR SKIN DISORDERS W CC	10	10	$139,526	16.9	2

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
226	SOFT TISSUE PROCEDURES W CC	7	7	$102,330	19.0	2
265	SKIN GRFT DEBRID EX SKN ULCER/CELL W CC	7	7	$72,445	18.2	2
440	WOUND DEBRIDEMENTS FOR INJURIES	7	7	$88,380	15.7	2
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	5	5	$75,512	11.8	2
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	4	4	$139,434	5.8	2
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	3	3	$68,699	14.8	2
16	NONSPEC CEREBROVASCULAR DISORDERS W CC	2	2	$1,388,438	804.0	2
174	G.I. HEMORRHAGE W CC	87	86	$41,826	4.9	1
522	ALC/DRG ABUSE/ DEPEND W REHAB THERAPY W/O CC	87	87	$29,586	9.6	1
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	78	78	$67,127	6.4	1
10	NERVOUS SYSTEM NEOPLASMS W CC	22	21	$33,414	127.0	1
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	21	21	$139,341	16.1	1
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	12	12	$86,027	30.8	1
144	OTHER CIRCULATORY SYSTEM DIAG W CC	7	7	$33,887	7.7	1
280	TRAUMA SKIN SUBCUT TIS/BREAST AGE 0-17	7	7	$63,254	30.9	1
131	PERIPHERAL VASCULAR DISORDERS W/O CC	6	6	$7,975	7.5	1
264	SKIN GRAFT DEBRID SKN ULCR/CELLITS WO CC	6	6	$177,102	18.2	1
464	SIGNS & SYMPTOMS W/O CC	5	5	$37,022	14.2	1
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	4	4	$91,626	33.3	1
17	NONSPEC CEREBROVASCULAR DISORDERS W/O CC	3	3	$34,401	14.0	1
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	3	3	$118,686	25.7	1
29	TRAUMATIC STPR/COMA <1 HR AGE >17 W/O CC	3	3	$2,726,497	836.0	1
85	PLEURAL EFFUSION W CC	3	3	$39,181	8.3	1
269	OTHR SKIN SUBCUT TISS/BREAST PROC W CC	3	3	$110,927	20.0	1
8	PERIPH/CRANL NERVE/OTHER NRV PROC W/O CC	2	2	$93,968	17.0	1
192	PANCREAS/LIVER/SHUT PROCEDURES W/O CC	2	2	$108,471	14.0	1
225	FOOT PROCEDURES	2	2	$106,487	20.0	1
151	PERITONEAL ADHESIOLYSIS W/O CC	1	1	$96,611	16.0	1
157	ANAL &STOMAL PROCEDURES W CC	1	1	$41,122	7.0	1
235	FRACTURES OF FEMUR	1	1	$12,106	8.0	1
283	MINOR SKIN DISORDERS W CC	1	1	$66,177	14.0	1

NOTE

See other supporting information summarizing 17 Northern California Hospitals.

Exhibit D

Southern California Transfer Discharges Analysis

Exhibit D

Southern California - Medicare Transfer Discharges

Hospital	City	Governance (1)	Occup. (2)	of Beds	Occupancy (3)	Discharge % (4)	Discharges (5)	Discharges (6)
El Centro Regional Medical Center	El Centro	City/County	N	165	47.6%	37.8%	2,582	6,832
LAC/Olive View - UCLA Med. Center	Olive View	City/County	N	238	69.3%	5.0%	621	12,325
Riverside County Regional Med. Center	Riverside	City/County	N	359	65.7%	9.3%	1,768	18,953
Ventura County Medical Center	Ventura	City/County	N	196	68.3%	12.3%	1,319	10,713
			Totals (12)	958	62.7%	16.1%	6,290	48,823
Antelope Valley Hospital Med. Center	Lancaster	District	N	332	75.8%	29.3%	6,547	22,344
Arrowhead Regional Medical Center	Colton	District	N	337	92.7%	6.5%	1,560	23,817
Fallbrook Hospital District	Fallbrook	District	N	146	61.9%	32.1%	948	2,956
Hemet Valley Medical Center	Hemet	District	Y, <80%	395	64.4%	64.9%	10,057	15,491
Hi-Desert Medical Center	Joshua Tree	District	Y, >80%	179	78.5%	46.6%	1,554	3,337
Lompoc Healthcare District	Lompoc	District	Y, >80%	170	73.5%	37.8%	1,025	2,715
Moreno Valley Community Hospital	Moreno Valley	District	N	101	57.7%	33.2%	1,872	5,647
Palomar Medical Center	Escondido	District	Y, >80%	417	75.6%	39.8%	8,502	21,377
Pomerado Hospital	Poway	District	Y, >80%	236	79.4%	47.3%	3,485	7,373
			Totals (12)	2,313	73.3%	37.5%	35,550	105,057
Beverly Hospital	Montebello	Nonprofit	N	223	56.8%	43.0%	4,428	10,287
Commun. Mem. Hosp. - San Buenaventura	Ventura	Nonprofit	N	237	73.5%	33.6%	5,918	17,605
Community Hospital of Long Beach	Long Beach	Nonprofit	N	147	32.5%	58.0%	1,977	3,406
Corona Regional Medical Center	Corona	Nonprofit	N	228	71.7%	38.7%	3,578	9,248
Downey Community Hospital	Downey	Nonprofit	N	193	64.9%	49.4%	5,902	11,959
Eisenhower Medical Center	Riverside	Nonprofit	N	253	77.4%	69.4%	11,107	16,005
Foothill Presbyterian Hospital	Glendora	Nonprofit	N	106	55.3%	46.7%	2,709	5,802
Good Samaritan - Los Angeles	Los Angeles	Nonprofit	Y, >80%	361	66.4%	41.2%	6,861	16,635
Henry Mayo Newhall Medical Center	Valencia	Nonprofit	Y, <80%	217	72.1%	34.8%	4,278	12,295
Methodist Hospital of Southern California	Arcadia	Nonprofit	Y, >80%	377	58.0%	41.6%	6,665	16,419
Parkview Community Hospital	Riverside	Nonprofit	N	193	46.7%	24.1%	1,913	7,947
Pomona Valley Hospital	Pomona	Nonprofit	Y, <80%	436	60.0%	29.2%	5,924	20,301
Presbyterian Intercommunity Hospital	Whittier	Nonprofit	Y, <80%	339	65.2%	40.8%	7,282	17,868
Providence Holy Cross Medical Center	Mission Hills	Nonprofit	Y, >80%	251	88.4%	36.2%	5,201	14,348
San Antonio Community Hospital	Upland	Nonprofit	N	283	57.7%	35.7%	5,163	14,472
Santa Barbara Cottage Hospital	Santa Barbara	Nonprofit	Y, <80%	295	72.4%	37.7%	7,029	18,639
Sherman Oaks Hospital & Health Center	Sherman Oaks	Nonprofit	Y, <80%	153	50.6%	65.5%	3,331	5,083
St. Joseph Hospital - Orange	Orange	Nonprofit	N	378	62.7%	33.4%	7,235	21,639
Torrance Memorial Medical Center	Torrance	Nonprofit	Y, >80%	355	75.7%	42.9%	9,879	23,019
Tri-City Regional Medical Center	Hawaiian Gardens	Nonprofit	N	125	24.3%	55.2%	1,395	2,527
Valley Presbyterian Hospital	Van Nuys	Nonprofit	N	290	53.5%	24.7%	2,953	11,960
Verdugo Hills Hospital	Glendale	Nonprofit	Y, >80%	158	72.4%	42.3%	2,664	6,294
			Totals (12)	5,598	61.7%	42.0%	113,392	283,758
			Regional Totals	8,869	64.8%	37.9%	155,232	437,638

Exhibit D

Southern California - Medicare Transfer Discharges

Hospital		Transfer DRGs (7)	Subtotal Transfer DRGs (8)	Top 25 DRGs as % of Total Transfer Discharge DRGs (8)	Total Transfer Discharge DRGs (9)	Expenses per Patient Day (10)	Proj. Loss in Medicare LOS (11)
El Centro Regional Medical Center		28	1,020	26.7%	3,826	$2,381.70	$351,262.26
LAC/Olive View - UCLA Med. Center		24	2,359	34.2%	6,902	$4,400.63	$156,097.04
Riverside County Regional Med. Center		27	4,760	44.8%	10,614	$2,949.24	$297,838.32
Ventura County Medical Center		23	1,990	33.2%	5,999	$3,997.62	$301,185.81
	Totals (12)	25.5	10,129	34.7%	27,341	$3,432.30	$276,595.86
Antelope Valley Hospital Med. Center		14	2,832	22.6%	12,513	$2,192.09	$819,764.15
Arrowhead Regional Medical Center		24	4,485	33.6%	13,338	$2,687.83	$239,505.01
Fallbrook Hospital District		31	530	32.0%	1,655	$893.36	$48,375.23
Hemet Valley Medical Center		32	3,837	44.2%	8,675	$1,004.22	$288,440.02
Hi-Desert Medical Center		37	1,279	68.4%	1,869	$837.83	$37,184.77
Lompoc Healthcare District		31	474	31.2%	1,520	$738.95	$21,632.02
Moreno Valley Community Hospital		25	905	28.6%	3,162	$1,806.09	$193,122.75
Palomar Medical Center		29	3,888	32.5%	11,971	$2,012.47	$488,662.17
Pomerado Hospital		38	1,879	45.5%	4,129	$1,293.53	$128,747.11
	Totals (12)	29.0	20,109	37.6%	58,832	$1,496.26	$251,714.80
Beverly Hospital		23	1,895	32.9%	5,761	$1,909.94	$483,076.08
Commun. Mem. Hosp. - San Buenaventura		22	1,609	16.3%	9,859	$2,564.37	$866,849.79
Community Hospital of Long Beach		35	1,509	79.1%	1,907	$1,980.99	$223,705.75
Corona Regional Medical Center		29	2,023	39.1%	5,179	$1,321.49	$270,079.99
Downey Community Hospital		24	2,310	34.5%	6,697	$2,810.65	$947,532.62
Eisenhower Medical Center		24	2,483	27.7%	8,963	$3,592.69	$2,279,316.93
Foothill Presbyterian Hospital		25	1,050	32.3%	3,249	$2,151.93	$332,985.52
Good Samaritan - Los Angeles		24	2,378	25.5%	9,316	$2,394.35	$469,173.27
Henry Mayo Newhall Medical Center		23	2,735	39.7%	6,885	$1,753.86	$214,286.05
Methodist Hospital of Southern California		22	3,087	33.6%	9,195	$1,983.95	$377,649.64
Parkview Community Hospital		26	1,156	26.0%	4,450	$2,215.89	$242,131.54
Pomona Valley Hospital		20	2,900	25.5%	11,369	$2,622.21	$443,650.24
Presbyterian Intercommunity Hospital		20	2,774	27.7%	10,006	$2,479.25	$515,619.34
Providence Holy Cross Medical Center		30	2,727	33.9%	8,035	$2,008.94	$298,409.07
San Antonio Community Hospital		22	2,066	25.5%	8,104	$3,334.13	$983,270.15
Santa Barbara Cottage Hospital		24	2,187	21.0%	10,438	$3,115.03	$625,336.79
Sherman Oaks Hospital & Health Center		30	1,711	60.1%	2,846	$2,271.69	$216,113.50
St. Joseph Hospital - Orange		23	3,245	26.8%	12,118	$4,317.12	$1,784,106.83
Torrance Memorial Medical Center		17	3,322	25.8%	12,891	$2,669.70	$753,240.48
Tri-City Regional Medical Center		35	918	64.9%	1,415	$3,100.00	$123,507.72
Valley Presbyterian Hospital		21	1,134	16.9%	6,698	$1,998.11	$337,031.92
Verdugo Hills Hospital		31	1,629	46.2%	3,525	$1,604.90	$244,213.91
	Totals (12)	25.0	46,848	34.6%	158,904	$2,463.69	$592,331.23
	Regional Totals	26.1	77,086	35.4%	245,077	$2,325.62	$468,660.11

Exhibit D

Southern California - Medicare Transfer Discharges

Notes

1 All District and Government owned hospitals having between 100 and 499 available versus licensed beds are included in this Analysis. None of the hospitals owned by Nonprofit chains that operate 1,000 or more beds or 5 hospitals are included in this Analysis except for these hospitals with 100-499 beds - Providence Holy Cross Medical Center in Mission Hills and St. Joseph Hospital in Orange, which are included for geographic and demographic balance.
Mission Community Hospital in Panorama is not included because of anomalies in data reported to OSHPD.

2 These symbols have the following definitions: Y, >80% - The occupancy rate for the hospital's LTC beds is in excess of 80%; Y, <80% - The occupancy rate for the hospital's LTC beds is less than 80%; N - The hospital does not have LTC beds.

3 Stated averages for Overall Occupancy and Medicare Discharge % are not weighted based on the number of beds at each hospital.

4 The total Medicare Discharges for 2004 divided by Total Discharges.

5 Annual total Medicare Discharges for 2004 as reported to OSHPD.

6 Annual total Discharges for 2004 as reported to OSHPD.

7 The number of Transfer DRGs within the Top 25 DRGs for each of the following categories: Number of Discharges, Average Length of Stay, and Average Charge Per Stay.

8 The number of transfer discharges assigned from the Transfer DRGs within the Top 25 DRGs for each of the following categories: Number of Discharges, Average Length of Stay, and Average Charge Per Stay.

9 Represents the Transfer DRGs within the Top 25 DRGs for each of the following categories: Number of Discharges, Average Length of Stay, and Average Charge Per Stay plus the number of discharges in the remaining Transfer DRGS based on 56% of the Total Discharges being assigned a Transfer DRG code. The 56% assumption is based on an independent report dated February 22, 2006, which analyzed all DRGs assigned to discharged Medicare patients for 2,988 hospitals nationwide.

10 Total Operating Expenses divided by Total Patient Days as reported to OSHPD.

11 The Projected Loss is based on an Analysis of a client's experience entitled Acute Medicare Transfer Discharges Analysis. Specifically, in this separate, but related Analysis, patients that were Medicare Transfer Discharges were individually placed in two separate groupings, those that exceeded the target reimbursable LOS by Medicare by 20% or more and those that were transferred sooner than that. Our focus is the 34% of the patients in the group that exceeded the targeted LOS by 20% or more. We assume that half of those patients were not clinically appropriate for discharge to a post-acute setting. We assume there are not one or more SNFs in the hospital service area with staff trained in the care of higher acuity patients, management and vendor support such as Pharmacy, such as the operating and clinical criteria of admissions to a licensing Medi-Cal Subacute unit, but that a relationship with a SNF in the service area could be established.
Utilizing the Expenses PPD for each hospital derived from OSHPD data, we applied that PPD for an average of one day in excess of the Average Length of Stay of each patient's DRG code, minus an estimated 40% for expenses including charity care and ancillary services, to 56% of the total Medicare Discharges of each hospital herein, with 50% of that total for those Hospitals that do not operate a SNF and only 25% for those that do operate a SNF.
With higher wages for hospitals compared to freestanding SNFs, Medicare patients as well as Medi-Cal, if applicable, it would be more fiscally prudent to place patients in an alternative setting other than the Hospital's LTC facility.

12 There is substantial fluctuation in Medicare Discharges as a percentage of Total Discharges, with the only four Southern California City/County Hospitals with between 100-499 beds having between 5.0% and 37.8% of Total Discharges being Medicare Discharges, a non-weighted average of 16.1%. For the nine District Hospitals in Southern California, Medicare Discharges as a percentage of Total Discharges ranged from 6.5% to 64.9%, a non-weighted average of 37.5%. We assessed 22 Nonprofit hospitals in Southern California with at least 100 beds, not including large organizations operating at least five hospitals or 1,000 beds except the two referenced in footnote (1). For Nonprofit Hospitals in Southern California, Medicare Discharges as a percentage of Total Discharges ranged from 24.1% to 69.4%, a non-weighted average of 42.0%.

Exhibit D
Discharges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Charge Per Stay	ALOS	# of Hospitals
430	PSYCHOSES	13,813	13,810	$17,785.29	9.1	16
127	HEART FAILURE & SHOCK	11,846	11,843	$23,124.11	5.9	35
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	9,485	9,483	$25,599.32	6.5	34
462	REHABILITATION	5,806	5,803	$25,930.49	15.9	16
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	4,720	4,719	$27,532.57	5.5	28
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	3,479	3,478	$18,384.30	4.4	27
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	3,396	3,395	$19,874.30	6.0	27
416	SEPTICEMIA AGE >17	3,043	3,042	$42,504.43	7.7	25
475	RESPIRATORY SYS DIAG W VENTILATOR SUPORT	2,557	2,557	$104,538.94	14.2	29
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	1,995	1,995	$81,539.44	11.4	25
316	RENAL FAILURE	1,397	1,397	$32,306.45	8.1	13
277	CELLULITIS AGE >17 W CC	1,126	1,126	$18,759.71	6.9	11
294	DIABETES AGE >35	992	992	$15,243.50	5.3	9
79	RESP INFECTN AGE >17 W CC	933	933	$43,376.11	10.1	11
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	790	790	$31,952.20	5.1	10
278	CELLULITIS AGE >17 W/O CC	757	757	$12,217.61	3.3	4
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	741	741	$15,713.76	5.7	4
395	RED BLOOD CELL DISORDERS AGE >17	735	735	$15,477.43	3.4	6
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	621	621	$87,151.83	13.6	24
1	CRANIOTOMY AGE >17 W CC	587	587	$117,253.54	13.0	17
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	524	524	$94,738.19	13.9	18
219	LWR EXTRM/HUMR EX HP,FT,FMR AGE>17 WO CC	522	521	$24,772.46	3.0	4
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	516	516	$427,633.52	79.0	9
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	452	452	$146,820.15	8.1	15
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	443	443	$106,227.43	13.7	27
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	401	401	$74,542.59	4.1	8
522	ALC/DRG ABUSE/ DEPEND W REHAB THERAPY W/O CC	358	358	$19,908.85	13.6	2
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	355	355	$88,204.64	88.4	8
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	354	354	$89,407.13	14.4	21
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	273	273	$179,112.75	11.5	15
497	SPINAL FUSION EXCEPT CERVICAL W CC	242	242	$101,708.97	7.8	14
236	FRACTURES OF HIP &PELVIS	218	217	$20,927.68	18.2	2
15	NONSPEC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	196	196	$76,414.01	54.1	4
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	172	172	$81,695.84	14.4	13
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	162	162	$105,365.13	14.3	24
263	SKIN GRAFT DEBRID SKN ULCR/CELLITIS W CC	148	148	$74,322.02	17.1	12
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	141	141	$61,351.86	13.0	7
180	G.I. OBSTRUCTION W CC	140	140	$18,792.55	17.1	4
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	136	136	$91,456.44	15.8	14
24	SEIZURE & HEADACHE AGE >17 W CC	136	136	$26,111.29	23.2	4
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	121	121	$78,525.91	13.8	9
238	OSTEOMYELITIS	111	111	$39,309.53	19.1	10

Exhibit D
Discharges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Charge Per Stay	ALOS	# of Hospitals
75	MAJOR CHEST PROCEDURES	107	107	$108,186.48	17.6	8
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	97	97	$50,945.72	6.6	4
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	93	93	$104,797.94	12.9	11
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	93	93	$96,065.89	16.1	14
197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	89	89	$67,653.90	10.7	12
150	PERITONEAL ADHESIOLYSIS W CC	81	81	$59,257.54	10.8	9
90	SIMPLE PNEUMONIA/PLEURISY AGE >17 W/O CC	79	79	$23,699.08	22.6	2
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	72	72	$103,627.75	11.7	10
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	67	67	$107,599.73	15.1	12
126	ACUTE & SUBACUTE ENDOCARDITIS	65	65	$82,502.78	19.6	13
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	57	57	$85,853.16	14.8	7
108	OTHER CARDIOTHORACIC PROCEDURES	56	56	$169,611.34	12.8	11
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	56	56	$81,218.71	11.0	8
7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	55	55	$71,267.64	12.9	8
28	TRAUMATIC STPR/COMA <1 HR AGE >17 W CC	53	53	$78,992.62	15.5	3
292	OTHR ENDOCRINE NUTRIT/METAB O.R. PROC W CC	49	49	$96,851.50	19.6	11
271	SKIN ULCERS	45	45	$27,779.60	35.4	6
188	OTHER DIGESTIVE SYSTEM DIAG AGE>17 W CC	44	44	$20,285.41	4.6	1
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	44	44	$89,095.77	14.1	6
253	FX/SP/ST/DIS UPARM,LOWLG EX FT >17 W CC	44	44	$31,126.48	12.4	2
440	WOUND DEBRIDEMENTS FOR INJURIES	43	43	$69,818.64	13.9	4
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	40	40	$96,692.75	50.7	5
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	40	40	$88,070.10	12.7	12
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	39	39	$346,405.32	43.0	3
146	RECTAL RESECTION W CC	37	37	$89,153.17	11.8	11
233	OTHR MUSKELET SYS/CONN TIS O.R. PR W CC	37	37	$85,350.72	11.2	3
92	INTERSTITIAL LUNG DISEASE W CC	30	30	$37,307.30	34.0	1
287	SKIN GRFT/WND DEBRID ENDOC NUTRIT/METAB	30	30	$59,795.38	17.0	8
149	MAJOR SMALL/LARGE BOWEL PROCS W/O CC	28	28	$37,302.35	6.6	2
304	KIDNEY,URETR/MJR BLADDR PR NONNEOPL W CC	28	28	$86,106.85	13.8	7
297	NUTRITNL/MISC METABOLIC DIS AGE>17 WO CC	27	27	$9,563.37	2.1	1
240	CONNECTIVE TISSUE DISORDERS W CC	25	25	$53,906.15	24.0	3
130	PERIPHERAL VASCULAR DISORDERS W CC	24	24	$19,034.75	5.7	1
82	RESPIRATORY NEOPLASMS	22	22	$16,452.32	23.3	1
172	DIGESTIVE MALIGNANCY W CC	21	21	$71,630.53	9.7	2
256	OTHR MUSKELETAL SYSTM/CONN TISS DIAG	19	19	$780,723.34	486.2	4
265	SKIN GRFT DEBRID EX SKN ULCER/CELL W CC	19	19	$61,794.00	17.4	5
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	18	18	$70,627.21	15.5	4
226	SOFT TISSUE PROCEDURES W CC	17	17	$88,119.47	18.0	4
285	AMPUT LWR LMB ENDOCRN NUTRIT/METABOL DIS	16	16	$93,233.14	16.3	8
269	OTHR SKIN SUBCUT TISS/BREAST PROC W CC	15	15	$57,898.57	13.9	2
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	14	14	$120,454.95	23.3	6
463	SIGNS & SYMPTOMS W CC	14	14	$12,212.86	16.3	1

Exhibit D
Discharges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Charge Per Stay	ALOS	# of Hospitals
235	FRACTURES OF FEMUR	13	13	$36,360.89	93.5	2
18	CRANIAL & PERIPHRL NERV DISORDERS W CC	11	11	$34,994.73	55.6	1
144	OTHER CIRCULATORY SYSTEM DIAG W CC	11	11	$59,340.00	6.1	1
85	PLEURAL EFFUSION W CC	9	9	$44,462.69	9.9	4
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	9	9	$23,698.36	16.3	3
464	SIGNS & SYMPTOMS W/O CC	9	9	$10,758.44	18.8	1
10	NERVOUS SYSTEM NEOPLASMS W CC	8	8	$8,015.75	8.6	1
280	TRAUMA SKIN SUBCUT TIS/BREAST AGE 0-17	8	8	$34,242.38	68.5	1
244	BONE DISEASE/SPECIFIC ARTHROPATHIES W CC	7	7	$227,414.84	1254.1	2
321	KIDNEY/URINARY TRACT INFECT AGE>17 WO CC	7	7	$31,303.29	73.0	1
501	KNEE PROCEDURES W PDX OF INFECTION W CC	6	6	$116,253.58	17.7	3
155	STMCH/ESOPHGL/DUODNL PROC AGE >17 W/O CC	5	5	$87,373.00	10.8	1
250	FX/SP/ST/DIS FORARM/HND/FT AGE>17 W CC	5	5	$48,701.13	92.8	2
16	NONSPEC CEREBROVASCULAR DISORDERS W CC	4	4	$69,943.00	10.8	1
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	4	4	$49,209.00	12.5	2
254	FX/SP/ST/DIS UPARM,LOWLG EX FT >17 WO CC	4	4	$63,797.50	139.0	1
83	MAJOR CHEST TRAUMA W CC	2	2	$35,468.00	8.5	1
86	PLEURAL EFFUSION W/O CC	2	2	$13,864.00	19.5	1
192	PANCREAS/LIVER/SHUNT PROCEDURES W/O CC	2	2	$97,799.00	12.0	2
241	CONNECTIVE TISSUE DISORDERS W/O CC	2	2	$72,991.00	13.5	2
245	BONE DISEASE/SPECIFIC ARTHROPATHIE WO CC	2	2	$14,367.50	53.5	1
272	MAJOR SKIN DISORDERS W CC	2	2	$40,974.00	11.5	1
402	LYMPH/NONACUT LEUK W OTHR O.R.PROC WO CC	2	2	$71,141.50	18.0	1
444	TRAUMATIC INJURY AGE >17 W CC	2	2	$22,051.00	16.0	1
445	TRAUMATIC INJURY AGE >17 W/O CC	2	2	$8,148.00	17.0	2
2	CRANIOTOMY AGE >17 W/O CC	1	1	$53,428.00	15.0	1
13	MULTIPLE SCLEROSIS/CEREBELLAR ATAXIA	1	1	$38,058.00	15.0	1
147	RECTAL RESECTION W/O CC	1	1	$31,845.00	8.0	1
218	LWR EXTRM/HUMR EX HIP,FT,FMR AGE>17 W CC	1	1	$54,121.00	17.0	1
225	FOOT PROCEDURES	1	1	$126,552.00	12.0	1
251	FX/SP/ST/DIS FORARM/HND/FT AGE>17 WO CC	1	1	$43,663.00	14.0	1
404	LYMPHOMA/NON-ACUTE LEUKEMIA W/O CC	1	1	$22,286.00	49.0	1
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	1	1	$96,184.00	14.0	1

NOTE: See other supporting information summarizing 35 Southern California Hospitals.

Exhibit D
ALOS

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Charge Per Stay	ALOS	# of Hospitals
244	BONE DISEASE/SPECIFIC ARTHROPATHIES W CC	7	7	$227,414.84	1254.1	2
256	OTHR MUSKELETAL SYSTM/CONN TISS DIAG	19	19	$780,723.34	486.2	4
254	FX/SP/ST/DIS UPARM,LOWLG EX FT >17 WO CC	4	4	$63,797.50	139.0	1
235	FRACTURES OF FEMUR	13	13	$36,360.89	93.5	2
250	FX/SP/ST/DIS FORARM/HND/FT AGE>17 W CC	5	5	$48,701.13	92.8	2
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	355	355	$88,204.64	88.4	8
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	516	516	$427,633.52	79.0	9
321	KIDNEY/URINARY TRACT INFECT AGE>17 WO CC	7	7	$31,303.29	73.0	1
280	TRAUMA SKIN SUBCUT TIS/BREAST AGE 0-17	8	8	$34,242.38	68.5	1
18	CRANIAL & PERIPHRL NERV DISORDERS W CC	11	11	$34,994.73	55.6	1
15	NONSPEC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	196	196	$76,414.01	54.1	4
245	BONE DISEASE/SPECIFIC ARTHROPATHIE WO CC	2	2	$14,367.50	53.5	1
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	40	40	$96,692.75	50.7	5
404	LYMPHOMA/NON-ACUTE LEUKEMIA W/O CC	1	1	$22,286.00	49.0	1
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	39	39	$346,405.32	43.0	3
271	SKIN ULCERS	45	45	$27,779.60	35.4	6
92	INTERSTITIAL LUNG DISEASE W CC	30	30	$37,307.30	34.0	1
240	CONNECTIVE TISSUE DISORDERS W CC	25	25	$53,906.15	24.0	3
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	14	14	$120,454.95	23.3	6
82	RESPIRATORY NEOPLASMS	22	22	$16,452.32	23.3	1
24	SEIZURE & HEADACHE AGE >17 W CC	136	136	$26,111.29	23.2	4
90	SIMPLE PNEUMONIA/PLEURISY AGE >17 W/O CC	79	79	$23,699.08	22.6	2
292	OTHR ENDOCRINE NUTRIT/METAB O.R. PROC W CC	49	49	$96,851.50	19.6	11
126	ACUTE & SUBACUTE ENDOCARDITIS	65	65	$82,502.78	19.6	13
86	PLEURAL EFFUSION W/O CC	2	2	$13,864.00	19.5	1
238	OSTEOMYELITIS	111	111	$39,309.53	19.1	10
464	SIGNS & SYMPTOMS W/O CC	9	9	$10,758.44	18.8	1
236	FRACTURES OF HIP &PELVIS	218	217	$20,927.68	18.2	2
226	SOFT TISSUE PROCEDURES W CC	17	17	$88,119.47	18.0	4
402	LYMPH/NONACUT LEUK W OTHR O.R.PROC WO CC	2	2	$71,141.50	18.0	1
501	KNEE PROCEDURES W PDX OF INFECTION W CC	6	6	$116,253.58	17.7	3
75	MAJOR CHEST PROCEDURES	107	107	$108,186.48	17.6	8
265	SKIN GRFT DEBRID EX SKN ULCER/CELL W CC	19	19	$61,794.00	17.4	5
180	G.I. OBSTRUCTION W CC	140	140	$18,792.55	17.1	4
263	SKIN GRAFT DEBRID SKN ULCR/CELLITIS W CC	148	148	$74,322.02	17.1	12
287	SKIN GRFT/WND DEBRID ENDOC NUTRIT/METAB	30	30	$59,795.38	17.0	8
445	TRAUMATIC INJURY AGE >17 W/O CC	2	2	$8,148.00	17.0	2
218	LWR EXTRM/HUMR EX HIP,FT,FMR AGE>17 W CC	1	1	$54,121.00	17.0	1
285	AMPUT LWR LMB ENDOCRN NUTRIT/METABOL DIS	16	16	$93,233.14	16.3	8
463	SIGNS & SYMPTOMS W CC	14	14	$12,212.86	16.3	1
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	9	9	$23,698.36	16.3	3
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	93	93	$96,065.89	16.1	14

Exhibit D
ALOS

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Charge Per Stay	ALOS	# of Hospitals
444	TRAUMATIC INJURY AGE >17 W CC	2	2	$22,051.00	16.0	1
462	REHABILITATION	5,806	5,803	$25,930.49	15.9	16
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	136	136	$91,456.44	15.8	14
28	TRAUMATIC STPR/COMA <1 HR AGE >17 W CC	53	53	$78,992.62	15.5	3
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	18	18	$70,627.21	15.5	4
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	67	67	$107,599.73	15.1	12
2	CRANIOTOMY AGE >17 W/O CC	1	1	$53,428.00	15.0	1
13	MULTIPLE SCLEROSIS/CEREBELLAR ATAXIA	1	1	$38,058.00	15.0	1
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	57	57	$85,853.16	14.8	7
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	172	172	$81,695.84	14.4	13
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	354	354	$89,407.13	14.4	21
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	162	162	$105,365.13	14.3	24
475	RESPIRATORY SYS DIAG W VENTILATOR SUPORT	2,557	2,557	$104,538.94	14.2	29
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	44	44	$89,095.77	14.1	6
251	FX/SP/ST/DIS FORARM/HND/FT AGE>17 WO CC	1	1	$43,663.00	14.0	1
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	1	1	$96,184.00	14.0	1
440	WOUND DEBRIDEMENTS FOR INJURIES	43	43	$69,818.64	13.9	4
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	524	524	$94,738.19	13.9	18
269	OTHR SKIN SUBCUT TISS/BREAST PROC W CC	15	15	$57,898.57	13.9	2
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	121	121	$78,525.91	13.8	9
304	KIDNEY,URETR/MJR BLADDR PR NONNEOPL W CC	28	28	$86,106.85	13.8	7
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	443	443	$106,227.43	13.7	27
522	ALC/DRG ABUSE/ DEPEND W REHAB THERAPY W/O CC	358	358	$19,908.85	13.6	2
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	621	621	$87,151.83	13.6	24
241	CONNECTIVE TISSUE DISORDERS W/O CC	2	2	$72,991.00	13.5	2
1	CRANIOTOMY AGE >17 W CC	587	587	$117,253.54	13.0	17
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	141	141	$61,351.86	13.0	7
7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	55	55	$71,267.64	12.9	8
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	93	93	$104,797.94	12.9	11
108	OTHER CARDIOTHORACIC PROCEDURES	56	56	$169,611.34	12.8	11
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	40	40	$88,070.10	12.7	12
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	4	4	$49,209.00	12.5	2
253	FX/SP/ST/DIS UPARM,LOWLG EX FT >17 W CC	44	44	$31,126.48	12.4	2
192	PANCREAS/LIVER/SHUNT PROCEDURES W/O CC	2	2	$97,799.00	12.0	2
225	FOOT PROCEDURES	1	1	$126,552.00	12.0	1
146	RECTAL RESECTION W CC	37	37	$89,153.17	11.8	11
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	72	72	$103,627.75	11.7	10
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	273	273	$179,112.75	11.5	15
272	MAJOR SKIN DISORDERS W CC	2	2	$40,974.00	11.5	1
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	1,995	1,995	$81,539.44	11.4	25
233	OTHR MUSKELET SYS/CONN TIS O.R. PR W CC	37	37	$85,350.72	11.2	3
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	56	56	$81,218.71	11.0	8
150	PERITONEAL ADHESIOLYSIS W CC	81	81	$59,257.54	10.8	9

Exhibit D
ALOS

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Charge Per Stay	ALOS	# of Hospitals
155	STMCH/ESOPHGL/DUODNL PROC AGE >17 W/O CC	5	5	$87,373.00	10.8	1
16	NONSPEC CEREBROVASCULAR DISORDERS W CC	4	4	$69,943.00	10.8	1
197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	89	89	$67,653.90	10.7	12
79	RESP INFECTN AGE >17 W CC	933	933	$43,376.11	10.1	11
85	PLEURAL EFFUSION W CC	9	9	$44,462.69	9.9	4
172	DIGESTIVE MALIGNANCY W CC	21	21	$71,630.53	9.7	2
430	PSYCHOSES	13,813	13,810	$17,785.29	9.1	16
10	NERVOUS SYSTEM NEOPLASMS W CC	8	8	$8,015.75	8.6	1
83	MAJOR CHEST TRAUMA W CC	2	2	$35,468.00	8.5	1
316	RENAL FAILURE	1,397	1,397	$32,306.45	8.1	13
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	452	452	$146,820.15	8.1	15
147	RECTAL RESECTION W/O CC	1	1	$31,845.00	8.0	1
497	SPINAL FUSION EXCEPT CERVICAL W CC	242	242	$101,708.97	7.8	14
416	SEPTICEMIA AGE >17	3,043	3,042	$42,504.43	7.7	25
277	CELLULITIS AGE >17 W CC	1,126	1,126	$18,759.71	6.9	11
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	97	97	$50,945.72	6.6	4
149	MAJOR SMALL/LARGE BOWEL PROCS W/O CC	28	28	$37,302.35	6.6	2
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	9,485	9,483	$25,599.32	6.5	34
144	OTHER CIRCULATORY SYSTEM DIAG W CC	11	11	$59,340.00	6.1	1
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	3,396	3,395	$19,874.30	6.0	27
127	HEART FAILURE & SHOCK	11,846	11,843	$23,124.11	5.9	35
130	PERIPHERAL VASCULAR DISORDERS W CC	24	24	$19,034.75	5.7	1
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	741	741	$15,713.76	5.7	4
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	4,720	4,719	$27,532.57	5.5	28
294	DIABETES AGE >35	992	992	$15,243.50	5.3	9
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	790	790	$31,952.20	5.1	10
188	OTHER DIGESTIVE SYSTEM DIAG AGE>17 W CC	44	44	$20,285.41	4.6	1
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	3,479	3,478	$18,384.30	4.4	27
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	401	401	$74,542.59	4.1	8
395	RED BLOOD CELL DISORDERS AGE >17	735	735	$15,477.43	3.4	6
278	CELLULITIS AGE >17 W/O CC	757	757	$12,217.61	3.3	4
219	LWR EXTRM/HUMR EX HP,FT,FMR AGE>17 WO CC	522	521	$24,772.46	3.0	4
297	NUTRITNL/MISC METABOLIC DIS AGE>17 WO CC	27	27	$9,563.37	2.1	1

NOTE: See other supporting information summarizing 35 Southern California Hospitals.

Exhibit D
Charges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Charge Per Stay	ALOS	# of Hospitals
256	OTHR MUSKELETAL SYSTM/CONN TISS DIAG	19	19	$780,723.34	486.2	4
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	516	516	$427,633.52	79.0	9
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	39	39	$346,405.32	43.0	3
244	BONE DISEASE/SPECIFIC ARTHROPATHIES W CC	7	7	$227,414.84	1254.1	2
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	273	273	$179,112.75	11.5	15
108	OTHER CARDIOTHORACIC PROCEDURES	56	56	$169,611.34	12.8	11
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	452	452	$146,820.15	8.1	15
225	FOOT PROCEDURES	1	1	$126,552.00	12.0	1
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	14	14	$120,454.95	23.3	6
1	CRANIOTOMY AGE >17 W CC	587	587	$117,253.54	13.0	17
501	KNEE PROCEDURES W PDX OF INFECTION W CC	6	6	$116,253.58	17.7	3
75	MAJOR CHEST PROCEDURES	107	107	$108,186.48	17.6	8
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	67	67	$107,599.73	15.1	12
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	443	443	$106,227.43	13.7	27
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	162	162	$105,365.13	14.3	24
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	93	93	$104,797.94	12.9	11
475	RESPIRATORY SYS DIAG W VENTILATOR SUPORT	2,557	2,557	$104,538.94	14.2	29
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	72	72	$103,627.75	11.7	10
497	SPINAL FUSION EXCEPT CERVICAL W CC	242	242	$101,708.97	7.8	14
192	PANCREAS/LIVER/SHUNT PROCEDURES W/O CC	2	2	$97,799.00	12.0	2
292	OTHR ENDOCRINE NUTRIT/METAB O.R. PROC W CC	49	49	$96,851.50	19.6	11
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	40	40	$96,692.75	50.7	5
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	1	1	$96,184.00	14.0	1
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	93	93	$96,065.89	16.1	14
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	524	524	$94,738.19	13.9	18
285	AMPUT LWR LMB ENDOCRN NUTRIT/METABOL DIS	16	16	$93,233.14	16.3	8
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	136	136	$91,456.44	15.8	14
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	354	354	$89,407.13	14.4	21
146	RECTAL RESECTION W CC	37	37	$89,153.17	11.8	11
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	44	44	$89,095.77	14.1	6
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	355	355	$88,204.64	88.4	8
226	SOFT TISSUE PROCEDURES W CC	17	17	$88,119.47	18.0	4
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	40	40	$88,070.10	12.7	12
155	STMCH/ESOPHGL/DUODNL PROC AGE >17 W/O CC	5	5	$87,373.00	10.8	1
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	621	621	$87,151.83	13.6	24
304	KIDNEY,URETR/MJR BLADDR PR NONNEOPL W CC	28	28	$86,106.85	13.8	7
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	57	57	$85,853.16	14.8	7
233	OTHR MUSKELET SYS/CONN TIS O.R. PR W CC	37	37	$85,350.72	11.2	3
126	ACUTE & SUBACUTE ENDOCARDITIS	65	65	$82,502.78	19.6	13
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	172	172	$81,695.84	14.4	13
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	1,995	1,995	$81,539.44	11.4	25
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	56	56	$81,218.71	11.0	8

Exhibit D
Charges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Charge Per Stay	ALOS	# of Hospitals
28	TRAUMATIC STPR/COMA <1 HR AGE >17 W CC	53	53	$78,992.62	15.5	3
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	121	121	$78,525.91	13.8	9
15	NONSPEC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	196	196	$76,414.01	54.1	4
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	401	401	$74,542.59	4.1	8
263	SKIN GRAFT DEBRID SKN ULCR/CELLITIS W CC	148	148	$74,322.02	17.1	12
241	CONNECTIVE TISSUE DISORDERS W/O CC	2	2	$72,991.00	13.5	2
172	DIGESTIVE MALIGNANCY W CC	21	21	$71,630.53	9.7	2
7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	55	55	$71,267.64	12.9	8
402	LYMPH/NONACUT LEUK W OTHR O.R.PROC WO CC	2	2	$71,141.50	18.0	1
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	18	18	$70,627.21	15.5	4
16	NONSPEC CEREBROVASCULAR DISORDERS W CC	4	4	$69,943.00	10.8	1
440	WOUND DEBRIDEMENTS FOR INJURIES	43	43	$69,818.64	13.9	4
197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	89	89	$67,653.90	10.7	12
254	FX/SP/ST/DIS UPARM,LOWLG EX FT >17 WO CC	4	4	$63,797.50	139.0	1
265	SKIN GRFT DEBRID EX SKN ULCER/CELL W CC	19	19	$61,794.00	17.4	5
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	141	141	$61,351.86	13.0	7
287	SKIN GRFT/WND DEBRID ENDOC NUTRIT/METAB	30	30	$59,795.38	17.0	8
144	OTHER CIRCULATORY SYSTEM DIAG W CC	11	11	$59,340.00	6.1	1
150	PERITONEAL ADHESIOLYSIS W CC	81	81	$59,257.54	10.8	9
269	OTHR SKIN SUBCUT TISS/BREAST PROC W CC	15	15	$57,898.57	13.9	2
218	LWR EXTRM/HUMR EX HIP,FT,FMR AGE>17 W CC	1	1	$54,121.00	17.0	1
240	CONNECTIVE TISSUE DISORDERS W CC	25	25	$53,906.15	24.0	3
2	CRANIOTOMY AGE >17 W/O CC	1	1	$53,428.00	15.0	1
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	97	97	$50,945.72	6.6	4
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	4	4	$49,209.00	12.5	2
250	FX/SP/ST/DIS FORARM/HND/FT AGE>17 W CC	5	5	$48,701.13	92.8	2
85	PLEURAL EFFUSION W CC	9	9	$44,462.69	9.9	4
251	FX/SP/ST/DIS FORARM/HND/FT AGE>17 WO CC	1	1	$43,663.00	14.0	1
79	RESP INFECTN AGE >17 W CC	933	933	$43,376.11	10.1	11
416	SEPTICEMIA AGE >17	3,043	3,042	$42,504.43	7.7	25
272	MAJOR SKIN DISORDERS W CC	2	2	$40,974.00	11.5	1
238	OSTEOMYELITIS	111	111	$39,309.53	19.1	10
13	MULTIPLE SCLEROSIS/CEREBELLAR ATAXIA	1	1	$38,058.00	15.0	1
92	INTERSTITIAL LUNG DISEASE W CC	30	30	$37,307.30	34.0	1
149	MAJOR SMALL/LARGE BOWEL PROCS W/O CC	28	28	$37,302.35	6.6	2
235	FRACTURES OF FEMUR	13	13	$36,360.89	93.5	2
83	MAJOR CHEST TRAUMA W CC	2	2	$35,468.00	8.5	1
18	CRANIAL & PERIPHRL NERV DISORDERS W CC	11	11	$34,994.73	55.6	1
280	TRAUMA SKIN SUBCUT TIS/BREAST AGE 0-17	8	8	$34,242.38	68.5	1
316	RENAL FAILURE	1,397	1,397	$32,306.45	8.1	13
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	790	790	$31,952.20	5.1	10
147	RECTAL RESECTION W/O CC	1	1	$31,845.00	8.0	1
321	KIDNEY/URINARY TRACT INFECT AGE>17 WO CC	7	7	$31,303.29	73.0	1

Exhibit D
Charges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Charge Per Stay	ALOS	# of Hospitals
253	FX/SP/ST/DIS UPARM,LOWLG EX FT >17 W CC	44	44	$31,126.48	12.4	2
271	SKIN ULCERS	45	45	$27,779.60	35.4	6
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	4,720	4,719	$27,532.57	5.5	28
24	SEIZURE & HEADACHE AGE >17 W CC	136	136	$26,111.29	23.2	4
462	REHABILITATION	5,806	5,803	$25,930.49	15.9	16
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	9,485	9,483	$25,599.32	6.5	34
219	LWR EXTRM/HUMR EX HP,FT,FMR AGE>17 WO CC	522	521	$24,772.46	3.0	4
90	SIMPLE PNEUMONIA/PLEURISY AGE >17 W/O CC	79	79	$23,699.08	22.6	2
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	9	9	$23,698.36	16.3	3
127	HEART FAILURE & SHOCK	11,846	11,843	$23,124.11	5.9	35
404	LYMPHOMA/NON-ACUTE LEUKEMIA W/O CC	1	1	$22,286.00	49.0	1
444	TRAUMATIC INJURY AGE >17 W CC	2	2	$22,051.00	16.0	1
236	FRACTURES OF HIP &PELVIS	218	217	$20,927.68	18.2	2
188	OTHER DIGESTIVE SYSTEM DIAG AGE>17 W CC	44	44	$20,285.41	4.6	1
522	ALC/DRG ABUSE/ DEPEND W REHAB THERAPY W/O CC	358	358	$19,908.85	13.6	2
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	3,396	3,395	$19,874.30	6.0	27
130	PERIPHERAL VASCULAR DISORDERS W CC	24	24	$19,034.75	5.7	1
180	G.I. OBSTRUCTION W CC	140	140	$18,792.55	17.1	4
277	CELLULITIS AGE >17 W CC	1,126	1,126	$18,759.71	6.9	11
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	3,479	3,478	$18,384.30	4.4	27
430	PSYCHOSES	13,813	13,810	$17,785.29	9.1	16
82	RESPIRATORY NEOPLASMS	22	22	$16,452.32	23.3	1
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	741	741	$15,713.76	5.7	4
395	RED BLOOD CELL DISORDERS AGE >17	735	735	$15,477.43	3.4	6
294	DIABETES AGE >35	992	992	$15,243.50	5.3	9
245	BONE DISEASE/SPECIFIC ARTHROPATHIE WO CC	2	2	$14,367.50	53.5	1
86	PLEURAL EFFUSION W/O CC	2	2	$13,864.00	19.5	1
278	CELLULITIS AGE >17 W/O CC	757	757	$12,217.61	3.3	4
463	SIGNS & SYMPTOMS W CC	14	14	$12,212.86	16.3	1
464	SIGNS & SYMPTOMS W/O CC	9	9	$10,758.44	18.8	1
297	NUTRITNL/MISC METABOLIC DIS AGE>17 WO CC	27	27	$9,563.37	2.1	1
445	TRAUMATIC INJURY AGE >17 W/O CC	2	2	$8,148.00	17.0	2
10	NERVOUS SYSTEM NEOPLASMS W CC	8	8	$8,015.75	8.6	1

NOTE: See other supporting information summarizing 35 Southern California Hospitals.

Exhibit D
Frequency

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Charge Per Stay	ALOS	# of Hospitals
127	HEART FAILURE & SHOCK	11,846	11,843	$23,124.11	5.9	35
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	9,485	9,483	$25,599.32	6.5	34
475	RESPIRATORY SYS DIAG W VENTILATOR SUPORT	2,557	2,557	$104,538.94	14.2	29
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	4,720	4,719	$27,532.57	5.5	28
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	443	443	$106,227.43	13.7	27
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	3,396	3,395	$19,874.30	6.0	27
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	3,479	3,478	$18,384.30	4.4	27
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	1,995	1,995	$81,539.44	11.4	25
416	SEPTICEMIA AGE >17	3,043	3,042	$42,504.43	7.7	25
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	621	621	$87,151.83	13.6	24
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	162	162	$105,365.13	14.3	24
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	354	354	$89,407.13	14.4	21
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	524	524	$94,738.19	13.9	18
1	CRANIOTOMY AGE >17 W CC	587	587	$117,253.54	13.0	17
430	PSYCHOSES	13,813	13,810	$17,785.29	9.1	16
462	REHABILITATION	5,806	5,803	$25,930.49	15.9	16
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	273	273	$179,112.75	11.5	15
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	452	452	$146,820.15	8.1	15
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	136	136	$91,456.44	15.8	14
497	SPINAL FUSION EXCEPT CERVICAL W CC	242	242	$101,708.97	7.8	14
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	93	93	$96,065.89	16.1	14
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	172	172	$81,695.84	14.4	13
316	RENAL FAILURE	1,397	1,397	$32,306.45	8.1	13
126	ACUTE & SUBACUTE ENDOCARDITIS	65	65	$82,502.78	19.6	13
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	40	40	$88,070.10	12.7	12
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	67	67	$107,599.73	15.1	12
263	SKIN GRAFT DEBRID SKN ULCR/CELLITIS W CC	148	148	$74,322.02	17.1	12
197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	89	89	$67,653.90	10.7	12
79	RESP INFECTN AGE >17 W CC	933	933	$43,376.11	10.1	11
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	93	93	$104,797.94	12.9	11
277	CELLULITIS AGE >17 W CC	1,126	1,126	$18,759.71	6.9	11
108	OTHER CARDIOTHORACIC PROCEDURES	56	56	$169,611.34	12.8	11
292	OTHR ENDOCRINE NUTRIT/METAB O.R. PROC W CC	49	49	$96,851.50	19.6	11
146	RECTAL RESECTION W CC	37	37	$89,153.17	11.8	11
238	OSTEOMYELITIS	111	111	$39,309.53	19.1	10
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	72	72	$103,627.75	11.7	10
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	790	790	$31,952.20	5.1	10
294	DIABETES AGE >35	992	992	$15,243.50	5.3	9
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	516	516	$427,633.52	79.0	9
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	121	121	$78,525.91	13.8	9
150	PERITONEAL ADHESIOLYSIS W CC	81	81	$59,257.54	10.8	9
75	MAJOR CHEST PROCEDURES	107	107	$108,186.48	17.6	8

Exhibit D
Frequency

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Charge Per Stay	ALOS	# of Hospitals
285	AMPUT LWR LMB ENDOCRN NUTRIT/METABOL DIS	16	16	$93,233.14	16.3	8
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	355	355	$88,204.64	88.4	8
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	56	56	$81,218.71	11.0	8
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	401	401	$74,542.59	4.1	8
7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	55	55	$71,267.64	12.9	8
287	SKIN GRFT/WND DEBRID ENDOC NUTRIT/METAB	30	30	$59,795.38	17.0	8
304	KIDNEY,URETR/MJR BLADDR PR NONNEOPL W CC	28	28	$86,106.85	13.8	7
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	57	57	$85,853.16	14.8	7
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	141	141	$61,351.86	13.0	7
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	44	44	$89,095.77	14.1	6
395	RED BLOOD CELL DISORDERS AGE >17	735	735	$15,477.43	3.4	6
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	14	14	$120,454.95	23.3	6
271	SKIN ULCERS	45	45	$27,779.60	35.4	6
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	40	40	$96,692.75	50.7	5
265	SKIN GRFT DEBRID EX SKN ULCER/CELL W CC	19	19	$61,794.00	17.4	5
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	97	97	$50,945.72	6.6	4
85	PLEURAL EFFUSION W CC	9	9	$44,462.69	9.9	4
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	741	741	$15,713.76	5.7	4
256	OTHR MUSKELETAL SYSTM/CONN TISS DIAG	19	19	$780,723.34	486.2	4
226	SOFT TISSUE PROCEDURES W CC	17	17	$88,119.47	18.0	4
15	NONSPEC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	196	196	$76,414.01	54.1	4
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	18	18	$70,627.21	15.5	4
440	WOUND DEBRIDEMENTS FOR INJURIES	43	43	$69,818.64	13.9	4
24	SEIZURE & HEADACHE AGE >17 W CC	136	136	$26,111.29	23.2	4
219	LWR EXTRM/HUMR EX HP,FT,FMR AGE>17 WO CC	522	521	$24,772.46	3.0	4
180	G.I. OBSTRUCTION W CC	140	140	$18,792.55	17.1	4
278	CELLULITIS AGE >17 W/O CC	757	757	$12,217.61	3.3	4
240	CONNECTIVE TISSUE DISORDERS W CC	25	25	$53,906.15	24.0	3
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	39	39	$346,405.32	43.0	3
501	KNEE PROCEDURES W PDX OF INFECTION W CC	6	6	$116,253.58	17.7	3
233	OTHR MUSKELET SYS/CONN TIS O.R. PR W CC	37	37	$85,350.72	11.2	3
28	TRAUMATIC STPR/COMA <1 HR AGE >17 W CC	53	53	$78,992.62	15.5	3
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	9	9	$23,698.36	16.3	3
269	OTHR SKIN SUBCUT TISS/BREAST PROC W CC	15	15	$57,898.57	13.9	2
244	BONE DISEASE/SPECIFIC ARTHROPATHIES W CC	7	7	$227,414.84	1254.1	2
192	PANCREAS/LIVER/SHUNT PROCEDURES W/O CC	2	2	$97,799.00	12.0	2
241	CONNECTIVE TISSUE DISORDERS W/O CC	2	2	$72,991.00	13.5	2
172	DIGESTIVE MALIGNANCY W CC	21	21	$71,630.53	9.7	2
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	4	4	$49,209.00	12.5	2
250	FX/SP/ST/DIS FORARM/HND/FT AGE>17 W CC	5	5	$48,701.13	92.8	2
149	MAJOR SMALL/LARGE BOWEL PROCS W/O CC	28	28	$37,302.35	6.6	2
235	FRACTURES OF FEMUR	13	13	$36,360.89	93.5	2
253	FX/SP/ST/DIS UPARM,LOWLG EX FT >17 W CC	44	44	$31,126.48	12.4	2

Exhibit D
Frequency

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Charge Per Stay	ALOS	# of Hospitals
90	SIMPLE PNEUMONIA/PLEURISY AGE >17 W/O CC	79	79	$23,699.08	22.6	2
236	FRACTURES OF HIP &PELVIS	218	217	$20,927.68	18.2	2
522	ALC/DRG ABUSE/ DEPEND W REHAB THERAPY W/O CC	358	358	$19,908.85	13.6	2
445	TRAUMATIC INJURY AGE >17 W/O CC	2	2	$8,148.00	17.0	2
83	MAJOR CHEST TRAUMA W CC	2	2	$35,468.00	8.5	1
10	NERVOUS SYSTEM NEOPLASMS W CC	8	8	$8,015.75	8.6	1
188	OTHER DIGESTIVE SYSTEM DIAG AGE>17 W CC	44	44	$20,285.41	4.6	1
225	FOOT PROCEDURES	1	1	$126,552.00	12.0	1
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	1	1	$96,184.00	14.0	1
155	STMCH/ESOPHGL/DUODNL PROC AGE >17 W/O CC	5	5	$87,373.00	10.8	1
402	LYMPH/NONACUT LEUK W OTHR O.R.PROC WO CC	2	2	$71,141.50	18.0	1
16	NONSPEC CEREBROVASCULAR DISORDERS W CC	4	4	$69,943.00	10.8	1
254	FX/SP/ST/DIS UPARM,LOWLG EX FT >17 WO CC	4	4	$63,797.50	139.0	1
144	OTHER CIRCULATORY SYSTEM DIAG W CC	11	11	$59,340.00	6.1	1
218	LWR EXTRM/HUMR EX HIP,FT,FMR AGE>17 W CC	1	1	$54,121.00	17.0	1
2	CRANIOTOMY AGE >17 W/O CC	1	1	$53,428.00	15.0	1
251	FX/SP/ST/DIS FORARM/HND/FT AGE>17 WO CC	1	1	$43,663.00	14.0	1
272	MAJOR SKIN DISORDERS W CC	2	2	$40,974.00	11.5	1
13	MULTIPLE SCLEROSIS/CEREBELLAR ATAXIA	1	1	$38,058.00	15.0	1
92	INTERSTITIAL LUNG DISEASE W CC	30	30	$37,307.30	34.0	1
18	CRANIAL & PERIPHRL NERV DISORDERS W CC	11	11	$34,994.73	55.6	1
280	TRAUMA SKIN SUBCUT TIS/BREAST AGE 0-17	8	8	$34,242.38	68.5	1
147	RECTAL RESECTION W/O CC	1	1	$31,845.00	8.0	1
321	KIDNEY/URINARY TRACT INFECT AGE>17 WO CC	7	7	$31,303.29	73.0	1
404	LYMPHOMA/NON-ACUTE LEUKEMIA W/O CC	1	1	$22,286.00	49.0	1
444	TRAUMATIC INJURY AGE >17 W CC	2	2	$22,051.00	16.0	1
130	PERIPHERAL VASCULAR DISORDERS W CC	24	24	$19,034.75	5.7	1
82	RESPIRATORY NEOPLASMS	22	22	$16,452.32	23.3	1
245	BONE DISEASE/SPECIFIC ARTHROPATHIE WO CC	2	2	$14,367.50	53.5	1
86	PLEURAL EFFUSION W/O CC	2	2	$13,864.00	19.5	1
463	SIGNS & SYMPTOMS W CC	14	14	$12,212.86	16.3	1
464	SIGNS & SYMPTOMS W/O CC	9	9	$10,758.44	18.8	1
297	NUTRITNL/MISC METABOLIC DIS AGE>17 WO CC	27	27	$9,563.37	2.1	1

NOTE: See other supporting information summarizing 35 Southern California Hospitals.

Exhibit E

Central Valley Transfer Discharges Analysis

Exhibit E

CA Central Valley - Medicare Transfer Discharges

Hospital	City	Type of Governance (1)	LTC Occup. (2)	Number of Beds	Overall Occupancy %(3)	Medicare Discharge %(4)	Medicare Discharges (5)	Total Discharges (6)
Central Valley								
Kern Medical Center	Kern	City/County	N	222	69.1%	8.2%	1,109	13,553
San Joaquin General Hospital	French Camp	City/County	N	181	72.2%	14.6%	1,458	9,967
			Totals (12)	403	70.7%	11.4%	2,567	23,520
Kaweah Delta District Hospital	Visalia	District	Y, >80%	485	75.5%	36.1%	7,809	21,650
Kern Valley Healthcare District	Lake Isabella	District	Y, >80%	101	78.1%	61.8%	804	1,300
Oak Valley District Hospital	Oakdale	District	Y, >80%	150	85.1%	44.5%	1,053	2,364
Sierra View District Hospital	Porterville	District	Y, >80%	157	69.4%	36.3%	2,808	7,738
Tulare District Hospital	Tulare	District	N	100	61.0%	36.6%	2,065	5,645
			Totals (12)	993	73.8%	43.1%	14,539	38,697
Clovis Community Hospital	Clovis	Nonprofit	N	110	71.5%	17.8%	1,674	9,393
Dameron Hospital	Stockton	Nonprofit	N	188	81.0%	38.2%	5,142	13,444
Delano Regional Medical Center	Delano	Nonprofit	Y, <80%	156	62.7%	32.4%	1,406	4,337
Emanuel Medical Center	Turlock	Nonprofit	Y, <80%	318	75.3%	37.1%	4,423	11,925
Lodi Memorial Hospital	Lodi	Nonprofit	N	172	69.0%	45.4%	3,449	7,597
Madera Community Hospital	Madera	Nonprofit	N	106	64.5%	29.3%	1,565	5,348
Memorial Hospital Modesto	Modesto	Nonprofit	N	311	79.7%	44.2%	7,834	17,734
San Joaquin Community Hospital	Bakersfield	Nonprofit	Y, <80%	168	80.9%	38.2%	3,454	9,037
St. Agnes Medical Center	Fresno	Nonprofit	N	330	82.1%	49.7%	11,261	22,653
St. Joseph's Medical Center of Stockton	Stockton	Nonprofit	Y, >80%	298	76.4%	45.3%	8,026	17,698
			Totals (12)	2,157	74.3%	37.8%	48,234	119,166
			Regional Totals	3,553	73.7%	36.2%	65,340	181,383

		Transfer DRGs (7)	Subtotal Transfer DRGs (8)	Top 25 DRGs as %of Total Transfer Discharge DRGs (8)	Total Transfer Discharge DRGs (9)	Expenses per Patient Day (10)	Proj. Loss for Medicare LOS (11)
Central Valley							
Kern Medical Center		25	1,760	23.2%	7,590	$3,133.10	$198,469.60
San Joaquin General Hospital		33	1,453	26.0%	5,582	$3,594.28	$299,335.09
	Totals (12)	29.0	3,213	24.6%	13,171	$3,363.69	$248,902.35
Kaweah Delta District Hospital		33	4,370	36.0%	12,124	$2,120.38	$472,897.83
Kern Valley Healthcare District		29	537	73.8%	728	$760.81	$17,469.90
Oak Valley District Hospital		36	563	42.5%	1,324	$836.95	$25,170.17
Sierra View District Hospital		29	1,342	31.0%	4,333	$2,085.82	$167,275.42
Tulare District Hospital		28	1,021	32.3%	3,161	$2,366.11	$279,089.30
	Totals (12)	31.0	7,833	43.1%	21,670	$1,634.01	$192,380.52
Clovis Community Hospital		23	757	14.4%	5,260	$3,134.45	$299,712.60
Dameron Hospital		20	1,479	19.6%	7,529	$2,156.43	$633,367.30
Delano Regional Medical Center		24	819	33.7%	2,429	$1,416.95	$113,796.27
Emanuel Medical Center		31	1,970	29.5%	6,678	$1,260.28	$318,399.36
Lodi Memorial Hospital		29	1,630	38.3%	4,254	$2,045.13	$402,904.68
Madera Community Hospital		27	898	30.0%	2,995	$2,180.06	$194,881.67
Memorial Hospital Modesto		22	2,473	24.9%	9,931	$3,288.68	$1,471,612.21
San Joaquin Community Hospital		24	1,469	29.0%	5,061	$2,153.77	$212,461.31
St. Agnes Medical Center		19	4,019	31.7%	12,686	$3,046.57	$1,959,640.10
St. Joseph's Medical Center of Stockton		26	3,125	31.5%	9,911	$2,731.20	$626,052.66
	Totals (12)	24.5	18,639	28.3%	66,733	$2,341.35	$623,282.82
	Regional Totals	28.6	29,685	32.2%	101,574	$2,253.59	$452,502.09

CA Central Valley - Medicare Transfer Discharges

Notes

1 All District and Government owned hospitals having between 100 and 499 available versus licensed beds are included in this Analysis. None of the hospitals owned by Nonprofit chains that operate 1,000 or more beds or 5 hospitals are included in this Analysis except for hospitals with 100-499 beds including Clovis Community Hospital, St. Josephs in Stockton, San Joaquin Community in Bakersfield and Memorial Hospital Modesto, which are included for geographic and demographic balance.

2 These symbols have the following definitions: Y, >80% - The occupancy rate for the hospital's LTC beds is in excess of 80%; Y, <80% - The occupancy rate for the hospital's LTC beds is less than 80%; N - The hospital does not have LTC beds.

3 Stated averages for Overall Occupancy and Medicare Discharge % are not weighted based on the number of beds at each hospital.

4 The total Medicare Discharges for 2004 divided by total Discharges.

5 Annual total Medicare Discharges for 2004 as reported to OSHPD.

6 Annual total Discharges for 2004 as reported to OSHPD.

7 The number of Transfer DRGs within the Top 25 DRGs for each of the following categories: Number of Discharges, Average Length of Stay, and Average Charge Per Stay.

8 The number of transfer discharges assigned from the Transfer DRGs within the Top 25 DRGs for each of the following categories: Number of Discharges, Average Length of Stay, and Average Charge Per Stay. The Subtotal of Transfer DRGs within the Top 25 DRGs as a percentage of overall Total Transfer Discharge DRGs.

9 Represents the Transfer DRGs within the Top 25 DRGs for each of the following categories: Number of Discharges, Average Length of Stay, and Average Charge Per Stay plus the number of discharges in the remaining Transfer DRGS based on 56% of the Total Discharges being assigned a Transfer DRG code. The 56% assumption is based on an independent report dated February 22, 2006, which analyzed all DRGs assigned to discharged Medicare patients for 2,988 hospitals

10 Total Operating Expenses divided by Total Patient Days as reported to OSHPD.

11 The Projected Loss is based on an Analysis of a client's experience entitled Acute Medicare Transfer Discharges Analysis. Specifically, in this separate, but related Analysis, patients that were Medicare Transfer Discharges were individually placed in two separate groupings, those that exceeded the target reimbursable LOS by Medicare by 20% or more and those that were transferred sooner than that. Our focus is the 34% of the patients in the group that exceeded the targeted LOS by 20% or more. We assume that half of those patients were not clinically appropriate for discharge to a post-acute setting. We assume there are not one or more SNFs in the hospital service area with staff trained in the care of higher acuity patients, management and vendor support such as Pharmacy, such as the operating and clinical criteria of admissions to a licensing Medi-Cal Subacute unit, but that a relationship with a SNF in the service area could be established.
Utilizing the Expenses PPD for each hospital derived from OSHPD data, we applied that PPD for an average of one day in excess of the Average Length of Stay of each patient's DRG code, minus an estimated 40% for expenses including charity care and ancillary services, to 56% of the total Medicare Discharges of each hospital herein, with 50% of that total for those Hospitals that do not operate a SNF and only 25% for those that do operate a SNF.
With higher wages for hospitals compared to freestanding SNFs, Medicare patients as well as Medi-Cal, if applicable, it would be more fiscally prudent to place patients in an alternative setting other than the Hospital's LTC facility.

12 There is substantial fluctuation in Medicare Discharges as a percentage of total discharges, with the only two Central Valley County Hospitals with between 100-499 beds having only 8.2% and 14.6% of Total Discharges being Medicare discharges. For the five District Hospitals in the Central Valley, Medicare Discharges as a percentage of Total Discharges ranged from 36.1% to 61.8%, a non-weighted average of 43.1%. We assessed all of the District/Gov'n. and Nonprofit hospitals in the Central Valley with at least 100 beds, not including Nonprofit organizations operating at least five hospitals or 1,000 beds, unless referenced in Note 1 above. For Nonprofit hospitals in the Central Valley, Medicare Discharges as a percentage of total discharges ranged from 17.8% to 49.7%, a non-weighted average of 37.8%.

Exhibit E
Discharges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	5,539	5,538	$24,853.99	8.7	17
127	HEART FAILURE &SHOCK	4,970	4,970	$24,612.80	5.8	17
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1,931	1,930	$29,889.73	11.1	14
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	1,745	1,745	$19,574.89	6.5	15
430	PSYCHOSES	1,734	1,727	$381,234.23	243.4	4
416	SEPTICEMIA AGE >17	1,690	1,689	$39,392.51	7.6	12
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	1,571	1,571	$20,327.52	7.8	12
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	1,210	1,210	$83,342.71	13.2	15
475	RESPIRATORY SYS DIAG W VENTILATOR SUPORT	1,175	1,174	$103,391.68	16.3	15
462	REHABILITATION	1,039	1,039	$28,583.60	13.9	4
277	CELLULITIS AGE >17 W CC	725	724	$23,630.26	6.7	7
316	RENAL FAILURE	605	605	$31,265.61	5.9	5
79	RESP INFECTN AGE >17 W CC	490	490	$32,827.24	9.3	6
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	431	431	$90,212.27	16.0	15
294	DIABETES AGE >35	344	344	$17,118.70	25.8	6
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	316	316	$32,974.32	8.3	6
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	304	304	$197,327.43	9.9	6
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	248	248	$100,314.55	15.6	14
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	219	219	$119,880.68	117.6	8
219	LWR EXTRM/HUMR EX HP,FT,FMR AGE>17 WO CC	193	193	$14,836.04	2.7	2
278	CELLULITIS AGE >17 W/O CC	176	176	$7,028.14	3.9	2
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	169	169	$64,508.35	12.3	7
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	166	166	$64,276.16	12.9	7
75	MAJOR CHEST PROCEDURES	156	156	$74,823.02	13.3	9
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	142	142	$278,177.14	16.1	6
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	129	129	$69,856.14	16.2	6
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	129	129	$174,823.92	27.3	2
271	SKIN ULCERS	107	107	$44,531.11	20.6	7
15	NONSPEC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	94	94	$62,609.10	111.1	2
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	92	92	$48,007.51	12.3	5
445	TRAUMATIC INJURY AGE >17 W/O CC	91	91	$10,609.58	1.2	1
1	CRANIOTOMY AGE >17 W CC	90	90	$148,051.25	12.9	4
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	88	88	$50,971.34	120.5	5
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	85	85	$132,472.79	18.1	10
236	FRACTURES OF HIP &PELVIS	80	79	$47,412.16	201.2	3
395	RED BLOOD CELL DISORDERS AGE >17	68	68	$13,865.94	4.8	2
238	OSTEOMYELITIS	59	58	$58,729.16	20.7	6
263	SKIN GRAFT DEBRID SKN ULCR/CELLITIS W CC	59	59	$86,557.58	16.2	4
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	59	59	$115,458.21	12.3	8
497	SPINAL FUSION EXCEPT CERVICAL W CC	58	58	$89,334.26	7.8	5
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	53	53	$77,529.67	14.0	7
463	SIGNS & SYMPTOMS W CC	51	51	$19,511.10	32.1	1

Exhibit E
Discharges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
180	G.I. OBSTRUCTION W CC	50	49	$27,386.78	28.3	2
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	49	49	$52,236.61	12.6	5
126	ACUTE & SUBACUTE ENDOCARDITIS	49	49	$83,355.50	21.2	7
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	48	48	$62,048.29	12.7	7
108	OTHER CARDIOTHORACIC PROCEDURES	45	45	$187,012.57	12.4	6
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	42	42	$57,766.01	21.4	6
285	AMPUT LWR LMB ENDOCRN NUTRIT/METABOL DIS	35	35	$42,073.55	12.5	5
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	34	34	$46,653.85	16.8	3
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	34	34	$102,457.39	9.3	4
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	33	33	$74,765.85	14.6	5
7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	30	30	$57,840.25	19.2	5
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	29	29	$495,644.49	190.2	5
150	PERITONEAL ADHESIOLYSIS W CC	29	29	$62,047.09	10.5	4
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	29	29	$75,843.41	13.4	4
197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	28	28	$55,433.63	8.4	3
18	CRANIAL & PERIPHRL NERV DISORDERS W CC	27	27	$22,312.31	25.3	2
24	SEIZURE & HEADACHE AGE >17 W CC	27	27	$193,546.22	49.0	1
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	23	23	$60,479.27	17.0	3
130	PERIPHERAL VASCULAR DISORDERS W CC	22	22	$10,844.14	4.8	1
226	SOFT TISSUE PROCEDURES W CC	21	21	$63,870.85	15.9	4
90	SIMPLE PNEUMONIA/PLEURISY AGE >17 W/O CC	19	19	$14,230.42	6.8	1
240	CONNECTIVE TISSUE DISORDERS W CC	18	18	$62,032.47	22.6	4
144	OTHER CIRCULATORY SYSTEM DIAG W CC	17	17	$43,766.62	7.8	2
297	NUTRITNL/MISC METABOLIC DIS AGE>17 WO CC	17	17	$7,306.76	2.5	1
287	SKIN GRFT/WND DEBRID ENDOC NUTRIT/METAB	16	16	$71,168.15	16.8	6
304	KIDNEY,URETR/MJR BLADDR PR NONNEOPL W CC	14	14	$72,293.00	15.5	4
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	13	13	$79,366.06	15.9	3
284	MINOR SKIN DISORDERS W/O CC	12	12	$44,534.17	79.8	1
331	OTHR KIDNY/URINARY TRCT DIAG AGE>17 W CC	12	12	$27,958.92	68.8	1
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	12	12	$83,183.22	35.4	3
239	PATHOLGCL FRACT/MUSKELETL/CON TISS MALIG	11	11	$31,234.91	9.9	1
253	FX/SP/ST/DIS UPARM,LOWLG EX FT >17 W CC	10	10	$16,990.60	39.6	1
155	STMCH/ESOPHGL/DUODNL PROC AGE >17 W/O CC	9	9	$81,391.56	16.2	1
280	TRAUMA SKIN SUBCUT TIS/BREAST AGE 0-17	9	9	$77,754.22	135.7	1
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	9	9	$63,599.57	13.1	2
10	NERVOUS SYSTEM NEOPLASMS W CC	8	8	$183,562.17	71.9	2
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	8	8	$110,506.25	18.3	1
146	RECTAL RESECTION W CC	8	8	$54,066.38	11.8	2
172	DIGESTIVE MALIGNANCY W CC	7	7	$25,299.04	17.5	2
78	PULMONARY EMBOLISM	6	6	$38,707.17	9.3	2
173	DIGESTIVE MALIGNANCY W/O CC	6	6	$90,903.88	462.1	2

Exhibit E
Discharges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	6	6	$66,891.00	13.8	3
264	SKIN GRAFT DEBRID SKN ULCR/CELLITS WO CC	5	5	$68,002.00	19.6	1
28	TRAUMATIC STPR/COMA <1 HR AGE >17 W CC	4	4	$85,208.75	198.5	1
92	INTERSTITIAL LUNG DISEASE W CC	4	4	$20,829.50	9.8	1
235	FRACTURES OF FEMUR	3	3	$46,300.33	137.0	1
444	TRAUMATIC INJURY AGE >17 W CC	3	3	$28,685.67	44.0	1
29	TRAUMATIC STPR/COMA <1 HR AGE >17 W/O CC	2	2	$17,672.00	91.5	1
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	2	2	$68,961.50	11.0	2
225	FOOT PROCEDURES	2	2	$27,784.00	10.0	1
16	NONSPEC CEREBROVASCULAR DISORDERS W CC	1	1	$100,009.00	14.0	1
157	ANAL &STOMAL PROCEDURES W CC	1	1	$21,735.00	5.0	1
218	LWR EXTRM/HUMR EX HIP,FT,FMR AGE>17 W CC	1	1	$54,687.00	29.0	1
234	OTHR MUSKELET SYS/CONN TIS O.R. PR WO CC	1	1	$25,328.00	9.0	1
265	SKIN GRFT DEBRID EX SKN ULCER/CELL W CC	1	1	$52,632.00	22.0	1
266	SKIN GRFT DEBRID EX SKN ULCER/CELL WO CC	1	1	$13,390.00	10.0	1
283	MINOR SKIN DISORDERS W CC	1	1	$113,501.00	41.0	1
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	1	1	$68,902.00	19.0	1

NOTE

See other supporting information summarizing 17 Central Valley Hospitals.

Exhibit E
ALOS

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
173	DIGESTIVE MALIGNANCY W/O CC	6	6	$90,903.88	462.1	2
430	PSYCHOSES	1,734	1,727	$381,234.23	243.4	4
236	FRACTURES OF HIP &PELVIS	80	79	$47,412.16	201.2	3
28	TRAUMATIC STPR/COMA <1 HR AGE >17 W CC	4	4	$85,208.75	198.5	1
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	29	29	$495,644.49	190.2	5
235	FRACTURES OF FEMUR	3	3	$46,300.33	137.0	1
280	TRAUMA SKIN SUBCUT TIS/BREAST AGE 0-17	9	9	$77,754.22	135.7	1
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	88	88	$50,971.34	120.5	5
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	219	219	$119,880.68	117.6	8
15	NONSPEC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	94	94	$62,609.10	111.1	2
29	TRAUMATIC STPR/COMA <1 HR AGE >17 W/O CC	2	2	$17,672.00	91.5	1
284	MINOR SKIN DISORDERS W/O CC	12	12	$44,534.17	79.8	1
10	NERVOUS SYSTEM NEOPLASMS W CC	8	8	$183,562.17	71.9	2
331	OTHR KIDNY/URINARY TRCT DIAG AGE>17 W CC	12	12	$27,958.92	68.8	1
24	SEIZURE & HEADACHE AGE >17 W CC	27	27	$193,546.22	49.0	1
444	TRAUMATIC INJURY AGE >17 W CC	3	3	$28,685.67	44.0	1
283	MINOR SKIN DISORDERS W CC	1	1	$113,501.00	41.0	1
253	FX/SP/ST/DIS UPARM,LOWLG EX FT >17 W CC	10	10	$16,990.60	39.6	1
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	12	12	$83,183.22	35.4	3
463	SIGNS & SYMPTOMS W CC	51	51	$19,511.10	32.1	1
218	LWR EXTRM/HUMR EX HIP,FT,FMR AGE>17 W CC	1	1	$54,687.00	29.0	1
180	G.I. OBSTRUCTION W CC	50	49	$27,386.78	28.3	2
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	129	129	$174,823.92	27.3	2
294	DIABETES AGE >35	344	344	$17,118.70	25.8	6
18	CRANIAL & PERIPHRL NERV DISORDERS W CC	27	27	$22,312.31	25.3	2
240	CONNECTIVE TISSUE DISORDERS W CC	18	18	$62,032.47	22.6	4
265	SKIN GRFT DEBRID EX SKN ULCER/CELL W CC	1	1	$52,632.00	22.0	1
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	42	42	$57,766.01	21.4	6
126	ACUTE & SUBACUTE ENDOCARDITIS	49	49	$83,355.50	21.2	7
238	OSTEOMYELITIS	59	58	$58,729.16	20.7	6
271	SKIN ULCERS	107	107	$44,531.11	20.6	7
264	SKIN GRAFT DEBRID SKN ULCR/CELLITS WO CC	5	5	$68,002.00	19.6	1
7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	30	30	$57,840.25	19.2	5
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	1	1	$68,902.00	19.0	1
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	8	8	$110,506.25	18.3	1
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	85	85	$132,472.79	18.1	10
172	DIGESTIVE MALIGNANCY W CC	7	7	$25,299.04	17.5	2
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	23	23	$60,479.27	17.0	3
287	SKIN GRFT/WND DEBRID ENDOC NUTRIT/METAB	16	16	$71,168.15	16.8	6
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	34	34	$46,653.85	16.8	3
475	RESPIRATORY SYS DIAG W VENTILATOR SUPORT	1,175	1,174	$103,391.68	16.3	15
263	SKIN GRAFT DEBRID SKN ULCR/CELLITIS W CC	59	59	$86,557.58	16.2	4

Exhibit E
ALOS

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
155	STMCH/ESOPHGL/DUODNL PROC AGE >17 W/O CC	9	9	$81,391.56	16.2	1
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	129	129	$69,856.14	16.2	6
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	142	142	$278,177.14	16.1	6
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	431	431	$90,212.27	16.0	15
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	13	13	$79,366.06	15.9	3
226	SOFT TISSUE PROCEDURES W CC	21	21	$63,870.85	15.9	4
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	248	248	$100,314.55	15.6	14
304	KIDNEY,URETR/MJR BLADDR PR NONNEOPL W CC	14	14	$72,293.00	15.5	4
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	33	33	$74,765.85	14.6	5
16	NONSPEC CEREBROVASCULAR DISORDERS W CC	1	1	$100,009.00	14.0	1
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	53	53	$77,529.67	14.0	7
462	REHABILITATION	1,039	1,039	$28,583.60	13.9	4
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	6	6	$66,891.00	13.8	3
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	29	29	$75,843.41	13.4	4
75	MAJOR CHEST PROCEDURES	156	156	$74,823.02	13.3	9
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	1,210	1,210	$83,342.71	13.2	15
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	9	9	$63,599.57	13.1	2
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	166	166	$64,276.16	12.9	7
1	CRANIOTOMY AGE >17 W CC	90	90	$148,051.25	12.9	4
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	48	48	$62,048.29	12.7	7
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	49	49	$52,236.61	12.6	5
285	AMPUT LWR LMB ENDOCRN NUTRIT/METABOL DIS	35	35	$42,073.55	12.5	5
108	OTHER CARDIOTHORACIC PROCEDURES	45	45	$187,012.57	12.4	6
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	169	169	$64,508.35	12.3	7
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	59	59	$115,458.21	12.3	8
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	92	92	$48,007.51	12.3	5
146	RECTAL RESECTION W CC	8	8	$54,066.38	11.8	2
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1,931	1,930	$29,889.73	11.1	14
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	2	2	$68,961.50	11.0	2
150	PERITONEAL ADHESIOLYSIS W CC	29	29	$62,047.09	10.5	4
225	FOOT PROCEDURES	2	2	$27,784.00	10.0	1
266	SKIN GRFT DEBRID EX SKN ULCER/CELL WO CC	1	1	$13,390.00	10.0	1
239	PATHOLGCL FRACT/MUSKELETL/CON TISS MALIG	11	11	$31,234.91	9.9	1
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	304	304	$197,327.43	9.9	6
92	INTERSTITIAL LUNG DISEASE W CC	4	4	$20,829.50	9.8	1
78	PULMONARY EMBOLISM	6	6	$38,707.17	9.3	2
79	RESP INFECTN AGE >17 W CC	490	490	$32,827.24	9.3	6
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	34	34	$102,457.39	9.3	4
234	OTHR MUSKELET SYS/CONN TIS O.R. PR WO CC	1	1	$25,328.00	9.0	1
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	5,539	5,538	$24,853.99	8.7	17
197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	28	28	$55,433.63	8.4	3

Exhibit E
ALOS

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	316	316	$32,974.32	8.3	6
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	1,571	1,571	$20,327.52	7.8	12
144	OTHER CIRCULATORY SYSTEM DIAG W CC	17	17	$43,766.62	7.8	2
497	SPINAL FUSION EXCEPT CERVICAL W CC	58	58	$89,334.26	7.8	5
416	SEPTICEMIA AGE >17	1,690	1,689	$39,392.51	7.6	12
90	SIMPLE PNEUMONIA/PLEURISY AGE >17 W/O CC	19	19	$14,230.42	6.8	1
277	CELLULITIS AGE >17 W CC	725	724	$23,630.26	6.7	7
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	1,745	1,745	$19,574.89	6.5	15
316	RENAL FAILURE	605	605	$31,265.61	5.9	5
127	HEART FAILURE &SHOCK	4,970	4,970	$24,612.80	5.8	17
157	ANAL &STOMAL PROCEDURES W CC	1	1	$21,735.00	5.0	1
130	PERIPHERAL VASCULAR DISORDERS W CC	22	22	$10,844.14	4.8	1
395	RED BLOOD CELL DISORDERS AGE >17	68	68	$13,865.94	4.8	2
278	CELLULITIS AGE >17 W/O CC	176	176	$7,028.14	3.9	2
219	LWR EXTRM/HUMR EX HP,FT,FMR AGE>17 WO CC	193	193	$14,836.04	2.7	2
297	NUTRITNL/MISC METABOLIC DIS AGE>17 WO CC	17	17	$7,306.76	2.5	1
445	TRAUMATIC INJURY AGE >17 W/O CC	91	91	$10,609.58	1.2	1

NOTE

See other supporting information summarizing 17 Central Valley Hospitals.

Exhibit E
Charges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	29	29	$495,644.49	190.2	5
430	PSYCHOSES	1,734	1,727	$381,234.23	243.4	4
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	142	142	$278,177.14	16.1	6
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	304	304	$197,327.43	9.9	6
24	SEIZURE & HEADACHE AGE >17 W CC	27	27	$193,546.22	49.0	1
108	OTHER CARDIOTHORACIC PROCEDURES	45	45	$187,012.57	12.4	6
10	NERVOUS SYSTEM NEOPLASMS W CC	8	8	$183,562.17	71.9	2
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	129	129	$174,823.92	27.3	2
1	CRANIOTOMY AGE >17 W CC	90	90	$148,051.25	12.9	4
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	85	85	$132,472.79	18.1	10
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	219	219	$119,880.68	117.6	8
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	59	59	$115,458.21	12.3	8
283	MINOR SKIN DISORDERS W CC	1	1	$113,501.00	41.0	1
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	8	8	$110,506.25	18.3	1
475	RESPIRATORY SYS DIAG W VENTILATOR SUPORT	1,175	1,174	$103,391.68	16.3	15
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	34	34	$102,457.39	9.3	4
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	248	248	$100,314.55	15.6	14
16	NONSPEC CEREBROVASCULAR DISORDERS W CC	1	1	$100,009.00	14.0	1
173	DIGESTIVE MALIGNANCY W/O CC	6	6	$90,903.88	462.1	2
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	431	431	$90,212.27	16.0	15
497	SPINAL FUSION EXCEPT CERVICAL W CC	58	58	$89,334.26	7.8	5
263	SKIN GRAFT DEBRID SKN ULCR/CELLITIS W CC	59	59	$86,557.58	16.2	4
28	TRAUMATIC STPR/COMA <1 HR AGE >17 W CC	4	4	$85,208.75	198.5	1
126	ACUTE & SUBACUTE ENDOCARDITIS	49	49	$83,355.50	21.2	7
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	1,210	1,210	$83,342.71	13.2	15
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	12	12	$83,183.22	35.4	3
155	STMCH/ESOPHGL/DUODNL PROC AGE >17 W/O CC	9	9	$81,391.56	16.2	1
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	13	13	$79,366.06	15.9	3
280	TRAUMA SKIN SUBCUT TIS/BREAST AGE 0-17	9	9	$77,754.22	135.7	1
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	53	53	$77,529.67	14.0	7
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	29	29	$75,843.41	13.4	4
75	MAJOR CHEST PROCEDURES	156	156	$74,823.02	13.3	9
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	33	33	$74,765.85	14.6	5
304	KIDNEY,URETR/MJR BLADDR PR NONNEOPL W CC	14	14	$72,293.00	15.5	4
287	SKIN GRFT/WND DEBRID ENDOC NUTRIT/METAB	16	16	$71,168.15	16.8	6
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	129	129	$69,856.14	16.2	6
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	2	2	$68,961.50	11.0	2
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	1	1	$68,902.00	19.0	1
264	SKIN GRAFT DEBRID SKN ULCR/CELLITS WO CC	5	5	$68,002.00	19.6	1
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	6	6	$66,891.00	13.8	3
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	169	169	$64,508.35	12.3	7
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	166	166	$64,276.16	12.9	7

Exhibit E
Charges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
226	SOFT TISSUE PROCEDURES W CC	21	21	$63,870.85	15.9	4
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	9	9	$63,599.57	13.1	2
15	NONSPEC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	94	94	$62,609.10	111.1	2
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	48	48	$62,048.29	12.7	7
150	PERITONEAL ADHESIOLYSIS W CC	29	29	$62,047.09	10.5	4
240	CONNECTIVE TISSUE DISORDERS W CC	18	18	$62,032.47	22.6	4
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	23	23	$60,479.27	17.0	3
238	OSTEOMYELITIS	59	58	$58,729.16	20.7	6
7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	30	30	$57,840.25	19.2	5
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	42	42	$57,766.01	21.4	6
197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	28	28	$55,433.63	8.4	3
218	LWR EXTRM/HUMR EX HIP,FT,FMR AGE>17 W CC	1	1	$54,687.00	29.0	1
146	RECTAL RESECTION W CC	8	8	$54,066.38	11.8	2
265	SKIN GRFT DEBRID EX SKN ULCER/CELL W CC	1	1	$52,632.00	22.0	1
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	49	49	$52,236.61	12.6	5
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	88	88	$50,971.34	120.5	5
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	92	92	$48,007.51	12.3	5
236	FRACTURES OF HIP &PELVIS	80	79	$47,412.16	201.2	3
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	34	34	$46,653.85	16.8	3
235	FRACTURES OF FEMUR	3	3	$46,300.33	137.0	1
284	MINOR SKIN DISORDERS W/O CC	12	12	$44,534.17	79.8	1
271	SKIN ULCERS	107	107	$44,531.11	20.6	7
144	OTHER CIRCULATORY SYSTEM DIAG W CC	17	17	$43,766.62	7.8	2
285	AMPUT LWR LMB ENDOCRN NUTRIT/METABOL DIS	35	35	$42,073.55	12.5	5
416	SEPTICEMIA AGE >17	1,690	1,689	$39,392.51	7.6	12
78	PULMONARY EMBOLISM	6	6	$38,707.17	9.3	2
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	316	316	$32,974.32	8.3	6
79	RESP INFECTN AGE >17 W CC	490	490	$32,827.24	9.3	6
316	RENAL FAILURE	605	605	$31,265.61	5.9	5
239	PATHOLGCL FRACT/MUSKELETL/CON TISS MALIG	11	11	$31,234.91	9.9	1
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1,931	1,930	$29,889.73	11.1	14
444	TRAUMATIC INJURY AGE >17 W CC	3	3	$28,685.67	44.0	1
462	REHABILITATION	1,039	1,039	$28,583.60	13.9	4
331	OTHR KIDNY/URINARY TRCT DIAG AGE>17 W CC	12	12	$27,958.92	68.8	1
225	FOOT PROCEDURES	2	2	$27,784.00	10.0	1
180	G.I. OBSTRUCTION W CC	50	49	$27,386.78	28.3	2
234	OTHR MUSKELET SYS/CONN TIS O.R. PR WO CC	1	1	$25,328.00	9.0	1
172	DIGESTIVE MALIGNANCY W CC	7	7	$25,299.04	17.5	2
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	5,539	5,538	$24,853.99	8.7	17
127	HEART FAILURE &SHOCK	4,970	4,970	$24,612.80	5.8	17
277	CELLULITIS AGE >17 W CC	725	724	$23,630.26	6.7	7

Exhibit E
Charges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
18	CRANIAL & PERIPHRL NERV DISORDERS W CC	27	27	$22,312.31	25.3	2
157	ANAL &STOMAL PROCEDURES W CC	1	1	$21,735.00	5.0	1
92	INTERSTITIAL LUNG DISEASE W CC	4	4	$20,829.50	9.8	1
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	1,571	1,571	$20,327.52	7.8	12
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	1,745	1,745	$19,574.89	6.5	15
463	SIGNS & SYMPTOMS W CC	51	51	$19,511.10	32.1	1
29	TRAUMATIC STPR/COMA <1 HR AGE >17 W/O CC	2	2	$17,672.00	91.5	1
294	DIABETES AGE >35	344	344	$17,118.70	25.8	6
253	FX/SP/ST/DIS UPARM,LOWLG EX FT >17 W CC	10	10	$16,990.60	39.6	1
219	LWR EXTRM/HUMR EX HP,FT,FMR AGE>17 WO CC	193	193	$14,836.04	2.7	2
90	SIMPLE PNEUMONIA/PLEURISY AGE >17 W/O CC	19	19	$14,230.42	6.8	1
395	RED BLOOD CELL DISORDERS AGE >17	68	68	$13,865.94	4.8	2
266	SKIN GRFT DEBRID EX SKN ULCER/CELL WO CC	1	1	$13,390.00	10.0	1
130	PERIPHERAL VASCULAR DISORDERS W CC	22	22	$10,844.14	4.8	1
445	TRAUMATIC INJURY AGE >17 W/O CC	91	91	$10,609.58	1.2	1
297	NUTRITNL/MISC METABOLIC DIS AGE>17 WO CC	17	17	$7,306.76	2.5	1
278	CELLULITIS AGE >17 W/O CC	176	176	$7,028.14	3.9	2

NOTE

See other supporting information summarizing 17 Central Valley Hospitals.

Exhibit E
Frequency

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	5,539	5,538	$24,853.99	8.7	17
127	HEART FAILURE &SHOCK	4,970	4,970	$24,612.80	5.8	17
475	RESPIRATORY SYS DIAG W VENTILATOR SUPORT	1,175	1,174	$103,391.68	16.3	15
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	431	431	$90,212.27	16.0	15
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	1,210	1,210	$83,342.71	13.2	15
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	1,745	1,745	$19,574.89	6.5	15
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	248	248	$100,314.55	15.6	14
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1,931	1,930	$29,889.73	11.1	14
416	SEPTICEMIA AGE >17	1,690	1,689	$39,392.51	7.6	12
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	1,571	1,571	$20,327.52	7.8	12
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	85	85	$132,472.79	18.1	10
75	MAJOR CHEST PROCEDURES	156	156	$74,823.02	13.3	9
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	219	219	$119,880.68	117.6	8
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	59	59	$115,458.21	12.3	8
126	ACUTE & SUBACUTE ENDOCARDITIS	49	49	$83,355.50	21.2	7
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	53	53	$77,529.67	14.0	7
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	169	169	$64,508.35	12.3	7
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	166	166	$64,276.16	12.9	7
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	48	48	$62,048.29	12.7	7
271	SKIN ULCERS	107	107	$44,531.11	20.6	7
277	CELLULITIS AGE >17 W CC	725	724	$23,630.26	6.7	7
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	142	142	$278,177.14	16.1	6
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	304	304	$197,327.43	9.9	6
108	OTHER CARDIOTHORACIC PROCEDURES	45	45	$187,012.57	12.4	6
287	SKIN GRFT/WND DEBRID ENDOC NUTRIT/METAB	16	16	$71,168.15	16.8	6
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	129	129	$69,856.14	16.2	6
238	OSTEOMYELITIS	59	58	$58,729.16	20.7	6
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	42	42	$57,766.01	21.4	6
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	316	316	$32,974.32	8.3	6
79	RESP INFECTN AGE >17 W CC	490	490	$32,827.24	9.3	6
294	DIABETES AGE >35	344	344	$17,118.70	25.8	6
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	29	29	$495,644.49	190.2	5
497	SPINAL FUSION EXCEPT CERVICAL W CC	58	58	$89,334.26	7.8	5
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	33	33	$74,765.85	14.6	5
7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	30	30	$57,840.25	19.2	5
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	49	49	$52,236.61	12.6	5
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	88	88	$50,971.34	120.5	5
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	92	92	$48,007.51	12.3	5
285	AMPUT LWR LMB ENDOCRN NUTRIT/METABOL DIS	35	35	$42,073.55	12.5	5
316	RENAL FAILURE	605	605	$31,265.61	5.9	5
430	PSYCHOSES	1,734	1,727	$381,234.23	243.4	4
1	CRANIOTOMY AGE >17 W CC	90	90	$148,051.25	12.9	4

Exhibit E
Frequency

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	34	34	$102,457.39	9.3	4
263	SKIN GRAFT DEBRID SKN ULCR/CELLITIS W CC	59	59	$86,557.58	16.2	4
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	29	29	$75,843.41	13.4	4
304	KIDNEY,URETR/MJR BLADDR PR NONNEOPL W CC	14	14	$72,293.00	15.5	4
226	SOFT TISSUE PROCEDURES W CC	21	21	$63,870.85	15.9	4
150	PERITONEAL ADHESIOLYSIS W CC	29	29	$62,047.09	10.5	4
240	CONNECTIVE TISSUE DISORDERS W CC	18	18	$62,032.47	22.6	4
462	REHABILITATION	1,039	1,039	$28,583.60	13.9	4
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	12	12	$83,183.22	35.4	3
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	13	13	$79,366.06	15.9	3
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	6	6	$66,891.00	13.8	3
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	23	23	$60,479.27	17.0	3
197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	28	28	$55,433.63	8.4	3
236	FRACTURES OF HIP &PELVIS	80	79	$47,412.16	201.2	3
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	34	34	$46,653.85	16.8	3
10	NERVOUS SYSTEM NEOPLASMS W CC	8	8	$183,562.17	71.9	2
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	129	129	$174,823.92	27.3	2
173	DIGESTIVE MALIGNANCY W/O CC	6	6	$90,903.88	462.1	2
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	2	2	$68,961.50	11.0	2
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	9	9	$63,599.57	13.1	2
15	NONSPEC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	94	94	$62,609.10	111.1	2
146	RECTAL RESECTION W CC	8	8	$54,066.38	11.8	2
144	OTHER CIRCULATORY SYSTEM DIAG W CC	17	17	$43,766.62	7.8	2
78	PULMONARY EMBOLISM	6	6	$38,707.17	9.3	2
180	G.I. OBSTRUCTION W CC	50	49	$27,386.78	28.3	2
172	DIGESTIVE MALIGNANCY W CC	7	7	$25,299.04	17.5	2
18	CRANIAL & PERIPHRL NERV DISORDERS W CC	27	27	$22,312.31	25.3	2
219	LWR EXTRM/HUMR EX HP,FT,FMR AGE>17 WO CC	193	193	$14,836.04	2.7	2
395	RED BLOOD CELL DISORDERS AGE >17	68	68	$13,865.94	4.8	2
278	CELLULITIS AGE >17 W/O CC	176	176	$7,028.14	3.9	2
24	SEIZURE & HEADACHE AGE >17 W CC	27	27	$193,546.22	49.0	1
283	MINOR SKIN DISORDERS W CC	1	1	$113,501.00	41.0	1
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	8	8	$110,506.25	18.3	1
16	NONSPEC CEREBROVASCULAR DISORDERS W CC	1	1	$100,009.00	14.0	1
28	TRAUMATIC STPR/COMA <1 HR AGE >17 W CC	4	4	$85,208.75	198.5	1
155	STMCH/ESOPHGL/DUODNL PROC AGE >17 W/O CC	9	9	$81,391.56	16.2	1
280	TRAUMA SKIN SUBCUT TIS/BREAST AGE 0-17	9	9	$77,754.22	135.7	1
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	1	1	$68,902.00	19.0	1
264	SKIN GRAFT DEBRID SKN ULCR/CELLITS WO CC	5	5	$68,002.00	19.6	1
218	LWR EXTRM/HUMR EX HIP,FT,FMR AGE>17 W CC	1	1	$54,687.00	29.0	1
265	SKIN GRFT DEBRID EX SKN ULCER/CELL W CC	1	1	$52,632.00	22.0	1

Exhibit E
Frequency

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
235	FRACTURES OF FEMUR	3	3	$46,300.33	137.0	1
284	MINOR SKIN DISORDERS W/O CC	12	12	$44,534.17	79.8	1
239	PATHOLGCL FRACT/MUSKELETL/CON TISS MALIG	11	11	$31,234.91	9.9	1
444	TRAUMATIC INJURY AGE >17 W CC	3	3	$28,685.67	44.0	1
331	OTHR KIDNY/URINARY TRCT DIAG AGE>17 W CC	12	12	$27,958.92	68.8	1
225	FOOT PROCEDURES	2	2	$27,784.00	10.0	1
234	OTHR MUSKELET SYS/CONN TIS O.R. PR WO CC	1	1	$25,328.00	9.0	1
157	ANAL &STOMAL PROCEDURES W CC	1	1	$21,735.00	5.0	1
92	INTERSTITIAL LUNG DISEASE W CC	4	4	$20,829.50	9.8	1
463	SIGNS & SYMPTOMS W CC	51	51	$19,511.10	32.1	1
29	TRAUMATIC STPR/COMA <1 HR AGE >17 W/O CC	2	2	$17,672.00	91.5	1
253	FX/SP/ST/DIS UPARM,LOWLG EX FT >17 W CC	10	10	$16,990.60	39.6	1
90	SIMPLE PNEUMONIA/PLEURISY AGE >17 W/O CC	19	19	$14,230.42	6.8	1
266	SKIN GRFT DEBRID EX SKN ULCER/CELL WO CC	1	1	$13,390.00	10.0	1
130	PERIPHERAL VASCULAR DISORDERS W CC	22	22	$10,844.14	4.8	1
445	TRAUMATIC INJURY AGE >17 W/O CC	91	91	$10,609.58	1.2	1
297	NUTRITNL/MISC METABOLIC DIS AGE>17 WO CC	17	17	$7,306.76	2.5	1

NOTE

See other supporting information summarizing 17 Central Valley Hospitals.

Exhibit F

For Profit Hospitals Transfer Discharges Analysis

Exhibit F

California For Profit Hospitals - Medicare Transfer Discharges

Region	Hospital (1)	City	LTC Occup. (2)	Number of Beds	Overall Occupancy (3)	Medicare Discharge % (4)	Medicare Discharges (5)	Total Discharges (6)
	ALHAMBRA HOSPITAL - ALHAMBRA	ALHAMBRA	Y, >80%	144	76.4%	61.3%	2,678	4,369
	ANAHEIM GENERAL HOSPITAL	ANAHEIM	N	101	88.8%	53.7%	1,617	3,013
	BELLFLOWER MEDICAL CENTER	BELLFLOWER	N	108	68.3%	32.6%	1,631	4,999
	CHINO VALLEY MEDICAL CENTER	CHINO	Y, <80%	126	41.4%	27.2%	1,678	6,163
	CITY OF ANGELS MEDICAL CENTER	LOS ANGELES	N	180	65.1%	30.8%	2,123	6,889
	COAST PLAZA DOCTORS HOSPITAL	NORWALK	Y, <80%	123	36.4%	38.7%	1,674	4,331
	DOCTORS' HOSP MED CTR OF MONTCLAIR	MONTCLAIR	N	102	56.8%	35.5%	2,088	5,887
	EAST LOS ANGELES DOCTOR'S HOSPITAL	LOS ANGELES	Y, >80%	127	57.1%	27.9%	1,028	3,678
	HUNTINGTON BEACH HOSPITAL	HUNTINGTON BEACH	Y, <80%	131	53.5%	48.7%	2,268	4,661
	LA PALMA INTERCOMMUNITY HOSPITAL	LA PALMA	N	141	43.0%	26.8%	1,275	4,755
	LANCASTER COMMUNITY HOSPITAL	LANCASTER	N	117	61.8%	59.7%	3,497	5,853
	LOS ANGELES COMMUNITY HOSPITAL	LOS ANGELES	Y, >80%	187	53.0%	25.1%	1,586	6,325
	LOS ANGELES METROPOLITAN MEDICAL CENTER	LOS ANGELES	N	201	56.1%	26.3%	1,894	7,214
	MEMORIAL HOSPITAL OF GARDENA	GARDENA	Y, <80%	172	68.6%	36.7%	1,591	4,332
	PACIFIC ALLIANCE MEDICAL CENTER	LOS ANGELES	N	138	62.4%	35.8%	2,046	5,716
	PACIFICA HOSPITAL OF THE VALLEY	SUN VALLEY	Y, >80%	227	73.9%	27.3%	1,557	5,689
	RIVERSIDE COMMUNITY HOSPITAL	RIVERSIDE	Y, <80%	345	65.1%	34.9%	5,946	17,025
	SOUTHWEST HEALTHCARE SYSTEM-MURRIETA	MURRIETA	N	176	78.2%	36.8%	5,965	16,193
	TEMPLE COMMUNITY HOSPITAL	LOS ANGELES	Y, <80%	170	41.6%	57.6%	1,971	3,421
NC	WATSONVILLE COMMUNITY HOSPITAL	WATSONVILLE	N	106	57.3%	29.4%	1,829	6,213
	WEST ANAHEIM MEDICAL CENTER	ANAHEIM	Y, <80%	219	50.7%	59.5%	5,552	9,330
			Totals (12)	3,341	59.8%	37.8%	51,494	136,056

		Top 25 Transfer DRGs (7)	Subtotal Transfer DRGs (8)	Top 25 DRGs as % of Total Transfer Discharge DRGs (8)	Total Transfer Discharge DRGs (9)	Expenses per Patient Day (10)	Proj. Loss in Medicare LOS (11)
	ALHAMBRA HOSPITAL - ALHAMBRA	29	1,910	1	2,447	$1,301.70	$99,558.81
	ANAHEIM GENERAL HOSPITAL	33	1,144	1	1,687	$1,605.63	$148,300.87
	BELLFLOWER MEDICAL CENTER	26	1,854	1	2,799	$1,461.31	$136,139.61
	CHINO VALLEY MEDICAL CENTER	29	1,120	0	3,451	$2,406.84	$115,344.63
	CITY OF ANGELS MEDICAL CENTER	33	1,101	0	3,858	$976.58	$118,425.72
	COAST PLAZA DOCTORS HOSPITAL	34	1,226	1	2,425	$3,412.47	$163,148.28
	DOCTORS' HOSP MED CTR OF MONTCLAIR	29	1,283	0	3,297	$2,007.32	$239,406.15
	EAST LOS ANGELES DOCTOR'S HOSPITAL	26	883	0	2,060	$1,397.05	$41,016.94
	HUNTINGTON BEACH HOSPITAL	29	1,988	1	2,610	$1,902.82	$123,253.41
	LA PALMA INTERCOMMUNITY HOSPITAL	28	1,705	1	2,663	$1,797.68	$130,921.44
	LANCASTER COMMUNITY HOSPITAL	25	1,413	0	3,278	$2,156.55	$430,767.93
	LOS ANGELES COMMUNITY HOSPITAL	28	616	0	3,542	$1,006.18	$45,576.09
	LOS ANGELES METROPOLITAN MEDICAL CENTER	29	2,863	1	4,040	$1,131.99	$122,464.66
	MEMORIAL HOSPITAL OF GARDENA	32	1,482	1	2,426	$1,392.41	$63,269.66
	PACIFIC ALLIANCE MEDICAL CENTER	29	1,302	0	3,201	$2,032.86	$237,575.31
	PACIFICA HOSPITAL OF THE VALLEY	27	2,192	1	3,186	$1,040.38	$46,263.53
	RIVERSIDE COMMUNITY HOSPITAL	21	2,038	0	9,534	$2,317.66	$393,579.83
	SOUTHWEST HEALTHCARE SYSTEM-MURRIETA	22	1,677	0	9,068	$2,531.87	$862,660.77
	TEMPLE COMMUNITY HOSPITAL	39	1,452	1	1,916	$1,415.56	$79,684.36
NC	WATSONVILLE COMMUNITY HOSPITAL	29	851	0	3,479	$4,047.07	$422,807.44
	WEST ANAHEIM MEDICAL CENTER	31	2,438	0	5,225	$1,474.94	$233,874.04
	Totals (12)	29.0	32,538	42.7%	76,191	$1,848.42	$202,573.31

Exhibit F

California For Profit Hospitals - Medicare Transfer Discharges

Notes

1 There are 26 For Profit owned hospitals having between 100 and 499 available versus licensed beds, 21 of which are included in this Analysis. One hospital is located in Northern California, Watsonville Community Hospital; the remainder are located in Southern California.

Pacific Healthcare System owns four hospitals; only the three largest, Los Angeles Metropolitan Medical Center, Anaheim General Hospital in Anaheim, and Bellflower Medical Center in Bellflower, are included in this Analysis. The excluded hospital is Tustin Hospital Medical Center in Tustin.

College Hospital in Costa Mesa, San Leandro Hospital in San Leandro, and University Community Medical Center in San Diego are not included because of anomalies in data reported to OSHPD.

Modesto Rehabilitation Hospital, which is owned by Ocadian Care Systems, is not included because of its rehabilitation focus. There are 21 hospitals with less than 100 beds not included in this Analysis, with several rehabilitation only hospitals.

None of the hospitals that are 100% owned by one of the three For Profit chains (Tenet, Kindred, HCA) that operate 1,000 or more beds and/or 5 hospitals are included in this Analysis. There are 49 hospitals owned by these three chains, 11 have under 100 available beds and 29 have 100-499 beds. Tenet operated 38 of these 49 hospitals as of 12/31/04. HCA owns 75% of a joint venture with the original nonprofit owner of Riverside Community Hospital that operates that hospital.

On its web site, OSHPD cautions that care must be taken in the interpretation and use of the data it makes available. We have attempted to independently verify some of the data utilized herein, but ultimately reliance for accuracy must be placed on the hospitals that submitted the data to OSHPD.

2 These symbols have the following definitions: Y, >80% - The occupancy rate for the hospital's LTC beds is in excess of 80%; Y, <80% - The occupancy rate for the hospital's LTC beds is less than 80%; N - The hospital does not have LTC beds.

3 Stated averages for Overall Occupancy and Medicare Discharge % are not weighted based on the number of beds at each hospital.

4 The total Medicare Discharges for 2004 divided by Total Discharges.

5 Annual total Medicare Discharges for 2004 as reported to OSHPD.

6 Annual total Discharges for 2004 as reported to OSHPD.

7 The number of Transfer DRGs within the Top 25 DRGs for each of the following categories: Number of Discharges, Average Length of Stay, and Average Charge Per Stay.

8 The number of transfer discharges assigned from the Transfer DRGs within the Top 25 DRGs for each of the following categories: Number of Discharges, Average Length of Stay, and Average Charge Per Stay.

9 Represents the Transfer DRGs within the Top 25 DRGs for each of the following categories: Number of Discharges, Average Length of Stay, and Average Charge Per Stay plus the number of discharges in the remaining Transfer DRGS based on 56% of the Total Discharges being assigned a Transfer DRG code. The 56% assumption is based on an independent report dated February 22, 2006, which analyzed all DRGs assigned to discharged Medicare patients for 2,988 hospitals nationwide.

10 Total Operating Expenses divided by Total Patient Days as reported to OSHPD.

11 The Projected Loss is based on an Analysis of a client's experience entitled Acute Medicare Transfer Discharges Analysis. Specifically, in this separate, but related Analysis, patients that were Medicare Transfer Discharges were individually placed in two separate groupings, those that exceeded the target reimbursable LOS by Medicare by 20% or more and those that were transferred sooner than that. Our focus is the 34% of the patients in the group that exceeded the targeted LOS by 20% or more. We assume that half of those patients were not clinically appropriate for discharge to a post-acute setting. We assume there are not one or more SNFs in the hospital service area with staff trained in the care of higher acuity patients, management and vendor support such as Pharmacy, such as the operating and clinical criteria of admissions to a licensing Medi-Cal Subacute unit, but that a relationship with a SNF in the service area could be established.
Utilizing the Expenses PPD for each hospital derived from OSHPD data, we applied that PPD for an average of one day in excess of the Average Length of Stay of each patient's DRG code, minus an estimated 40% for expenses including charity care and ancillary services, to 56% of the total Medicare Discharges of each hospital herein, with 50% of that total for those Hospitals that do not operate a SNF and only 25% for those that do operate a SNF.
With higher wages for hospitals compared to freestanding SNFs, Medicare patients as well as Medi-Cal, if applicable, it would be more fiscally prudent to place patients in an alternative setting other than the Hospital's LTC facility.
It is assumed that hospitals provide more charity care in Los Angeles County, especially in the City of Los Angeles, than the rest of California. Five of the hospitals are in the City of Los Angeles and 12 are in the County of Los Angeles.

12 There is substantial fluctuation in Medicare Discharges as a percentage of Total Discharges, with the For Profit Hospitals having between 25.1% and 61.3% of Total Discharges being Medicare Discharges, an average of 37.8%.

Exhibit F
Discharges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
430	PSYCHOSES	6,930	6,927	$15,907.27	9.4	7
127	HEART FAILURE &SHOCK	4,446	4,444	$22,313.71	5.1	21
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	3,694	3,694	$24,035.14	5.8	20
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	1,652	1,652	$16,637.17	4.4	19
416	SEPTICEMIA AGE >17	1,649	1,649	$41,304.54	8.2	17
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	1,550	1,550	$18,048.94	4.9	18
475	RESPIRATORY SYS DIAG W VENTILATOR SUPORT	1,358	1,358	$179,123.71	24.0	21
462	REHABILITATION	1,191	1,188	$174,457.05	51.3	6
79	RESP INFECTN AGE >17 W CC	1,159	1,159	$51,884.88	12.2	17
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1,010	1,010	$23,938.88	6.6	12
316	RENAL FAILURE	964	964	$25,304.73	6.4	12
294	DIABETES AGE >35	903	903	$12,613.81	4.0	14
277	CELLULITIS AGE >17 W CC	659	659	$16,501.32	5.5	11
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	653	653	$40,018.27	7.2	9
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	638	638	$78,005.22	12.7	21
395	RED BLOOD CELL DISORDERS AGE >17	396	396	$15,213.82	4.4	9
188	OTHER DIGESTIVE SYSTEM DIAG AGE>17 W CC	337	337	$21,234.59	5.7	5
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	301	301	$99,000.36	16.1	20
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	237	237	$73,089.65	13.4	18
24	SEIZURE & HEADACHE AGE >17 W CC	196	196	$15,501.71	4.6	3
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	186	186	$100,296.99	13.5	20
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	129	128	$105,061.14	22.3	15
497	SPINAL FUSION EXCEPT CERVICAL W CC	117	117	$109,513.04	6.0	6
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	117	117	$89,201.88	4.6	5
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	114	114	$69,286.59	14.5	13
144	OTHER CIRCULATORY SYSTEM DIAG W CC	108	108	$23,767.27	6.1	3
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	107	107	$12,829.55	7.5	2
1	CRANIOTOMY AGE >17 W CC	101	101	$72,846.10	13.1	7
297	NUTRITNL/MISC METABOLIC DIS AGE>17 WO CC	93	92	$20,477.57	9.0	3
25	SEIZURE & HEADACHE AGE >17 W/O CC	87	87	$8,871.24	3.0	2
278	CELLULITIS AGE >17 W/O CC	87	87	$12,006.50	3.5	2
15	NONSPEC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	85	85	$17,100.41	5.9	2
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	70	70	$82,501.52	13.9	9
263	SKIN GRAFT DEBRID SKN ULCR/CELLITIS W CC	66	66	$60,745.83	12.7	6
130	PERIPHERAL VASCULAR DISORDERS W CC	65	65	$15,028.32	6.3	2
75	MAJOR CHEST PROCEDURES	59	59	$83,606.12	15.5	13
82	RESPIRATORY NEOPLASMS	58	58	$93,914.02	8.7	3
197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	58	58	$73,185.65	10.4	11
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	51	51	$116,174.51	75.6	2
236	FRACTURES OF HIP &PELVIS	51	51	$23,741.83	11.8	3
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	38	38	$72,564.59	12.0	6
271	SKIN ULCERS	38	38	$29,941.79	10.8	2

Exhibit F
Discharges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	38	38	$124,204.06	41.1	5
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	35	35	$204,819.88	16.2	2
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	32	32	$66,254.10	15.4	6
150	PERITONEAL ADHESIOLYSIS W CC	31	31	$65,181.86	12.2	7
16	NONSPEC CEREBROVASCULAR DISORDERS W CC	28	28	$469,676.22	217.9	3
269	OTHR SKIN SUBCUT TISS/BREAST PROC W CC	26	24	$47,021.07	11.0	5
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	24	24	$118,186.98	9.0	2
7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	22	22	$52,190.85	10.5	7
146	RECTAL RESECTION W CC	21	21	$81,678.18	12.1	11
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	20	20	$82,775.42	13.9	4
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	20	20	$40,579.93	9.8	4
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	19	19	$56,026.35	13.4	7
226	SOFT TISSUE PROCEDURES W CC	19	19	$62,806.73	11.3	6
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	18	18	$318,842.86	125.5	3
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	18	18	$76,632.37	14.6	7
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	18	18	$109,781.15	15.1	2
126	ACUTE & SUBACUTE ENDOCARDITIS	17	17	$94,851.85	14.4	6
292	OTHR ENDOCRINE NUTRIT/METAB O.R. PROC W CC	15	15	$78,793.50	17.8	5
189	OTHER DIGESTIVE SYSTM DIAG AGE>17 W/O CC	14	14	$18,539.14	80.5	1
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	14	14	$92,417.92	12.5	7
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	14	14	$90,561.54	13.0	6
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	13	13	$76,708.16	15.7	5
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	11	11	$50,015.40	12.1	3
238	OSTEOMYELITIS	11	11	$54,080.88	10.0	4
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	11	11	$115,505.53	10.6	4
78	PULMONARY EMBOLISM	10	10	$42,677.38	12.8	4
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	10	10	$63,020.81	11.5	4
18	CRANIAL & PERIPHRL NERV DISORDERS W CC	9	9	$498,348.22	167.0	1
108	OTHER CARDIOTHORACIC PROCEDURES	9	9	$159,093.13	15.8	2
501	KNEE PROCEDURES W PDX OF INFECTION W CC	9	9	$107,899.33	14.4	3
155	STMCH/ESOPHGL/DUODNL PROC AGE >17 W/O CC	8	8	$57,604.61	6.0	3
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	8	8	$39,774.17	13.1	6
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	8	8	$17,331.75	11.9	2
172	DIGESTIVE MALIGNANCY W CC	7	7	$42,112.86	8.0	1
233	OTHR MUSKELET SYS/CONN TIS O.R. PR W CC	7	7	$54,610.58	11.1	4
92	INTERSTITIAL LUNG DISEASE W CC	6	6	$83,320.67	12.2	2
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	5	5	$48,686.00	17.0	5
149	MAJOR SMALL/LARGE BOWEL PROCS W/O CC	5	5	$55,962.63	9.8	2
157	ANAL &STOMAL PROCEDURES W CC	5	5	$46,812.00	8.5	2
304	KIDNEY,URETR/MJR BLADDR PR NONNEOPL W CC	5	5	$67,311.33	14.2	3
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	5	5	$262,905.40	32.6	1
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	4	4	$392,485.25	7.0	1
241	CONNECTIVE TISSUE DISORDERS W/O CC	4	4	$41,158.00	10.5	2

Exhibit F
Discharges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
2	CRANIOTOMY AGE >17 W/O CC	3	3	$58,602.67	8.7	1
240	CONNECTIVE TISSUE DISORDERS W CC	3	3	$62,432.67	9.0	1
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	3	3	$85,156.67	16.3	3
502	KNEE PROCEDURES W PDX OF INFECTION WO CC	3	3	$67,193.25	23.3	2
10	NERVOUS SYSTEM NEOPLASMS W CC	2	2	$65,825.50	9.0	1
28	TRAUMATIC STPR/COMA <1 HR AGE >17 W CC	2	2	$132,716.50	49.5	2
85	PLEURAL EFFUSION W CC	2	2	$55,525.50	17.5	1
218	LWR EXTRM/HUMR EX HIP,FT,FMR AGE>17 W CC	2	2	$73,195.50	20.0	1
244	BONE DISEASE/SPECIFIC ARTHROPATHIES W CC	2	2	$15,838.00	8.5	1
86	PLEURAL EFFUSION W/O CC	1	1	$33,654.00	8.0	1
145	OTHER CIRCULATORY SYSTEM DIAG W/O CC	1	1	$24,430.00	13.0	1
151	PERITONEAL ADHESIOLYSIS W/O CC	1	1	$31,507.00	11.0	1
192	PANCREAS/LIVER/SHUNT PROCEDURES W/O CC	1	1	$56,012.00	12.0	1
239	PATHOLGCL FRACT/MUSKELETL/CON TISS MALIG	1	1	$36,051.00	10.0	1
256	OTHR MUSKELETAL SYSTM/CONN TISS DIAG	1	1	$31,658.00	13.0	1
273	MAJOR SKIN DISORDERS W/O CC	1	1	$21,224.00	8.0	1

Exhibit F
ALOS

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
16	NONSPEC CEREBROVASCULAR DISORDERS W CC	28	28	$469,676.22	217.9	3
18	CRANIAL & PERIPHRL NERV DISORDERS W CC	9	9	$498,348.22	167.0	1
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	18	18	$318,842.86	125.5	3
189	OTHER DIGESTIVE SYSTM DIAG AGE>17 W/O CC	14	14	$18,539.14	80.5	1
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	51	51	$116,174.51	75.6	2
462	REHABILITATION	1,191	1,188	$174,457.05	51.3	6
28	TRAUMATIC STPR/COMA <1 HR AGE >17 W CC	2	2	$132,716.50	49.5	2
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	38	38	$124,204.06	41.1	5
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	5	5	$262,905.40	32.6	1
475	RESPIRATORY SYS DIAG W VENTILATOR SUPORT	1,358	1,358	$179,123.71	24.0	21
502	KNEE PROCEDURES W PDX OF INFECTION WO CC	3	3	$67,193.25	23.3	2
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	129	128	$105,061.14	22.3	15
218	LWR EXTRM/HUMR EX HIP,FT,FMR AGE>17 W CC	2	2	$73,195.50	20.0	1
292	OTHR ENDOCRINE NUTRIT/METAB O.R. PROC W CC	15	15	$78,793.50	17.8	5
85	PLEURAL EFFUSION W CC	2	2	$55,525.50	17.5	1
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	5	5	$48,686.00	17.0	5
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	3	3	$85,156.67	16.3	3
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	35	35	$204,819.88	16.2	2
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	301	301	$99,000.36	16.1	20
108	OTHER CARDIOTHORACIC PROCEDURES	9	9	$159,093.13	15.8	2
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	13	13	$76,708.16	15.7	5
75	MAJOR CHEST PROCEDURES	59	59	$83,606.12	15.5	13
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	32	32	$66,254.10	15.4	6
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	18	18	$109,781.15	15.1	2
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	18	18	$76,632.37	14.6	7
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	114	114	$69,286.59	14.5	13
501	KNEE PROCEDURES W PDX OF INFECTION W CC	9	9	$107,899.33	14.4	3
126	ACUTE & SUBACUTE ENDOCARDITIS	17	17	$94,851.85	14.4	6
304	KIDNEY,URETR/MJR BLADDR PR NONNEOPL W CC	5	5	$67,311.33	14.2	3
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	20	20	$82,775.42	13.9	4
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	70	70	$82,501.52	13.9	9
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	186	186	$100,296.99	13.5	20
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	19	19	$56,026.35	13.4	7
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	237	237	$73,089.65	13.4	18
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	8	8	$39,774.17	13.1	6
1	CRANIOTOMY AGE >17 W CC	101	101	$72,846.10	13.1	7
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	14	14	$90,561.54	13.0	6
145	OTHER CIRCULATORY SYSTEM DIAG W/O CC	1	1	$24,430.00	13.0	1
256	OTHR MUSKELETAL SYSTM/CONN TISS DIAG	1	1	$31,658.00	13.0	1
78	PULMONARY EMBOLISM	10	10	$42,677.38	12.8	4
263	SKIN GRAFT DEBRID SKN ULCR/CELLITIS W CC	66	66	$60,745.83	12.7	6
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	638	638	$78,005.22	12.7	21

Exhibit F
ALOS

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	14	14	$92,417.92	12.5	7
150	PERITONEAL ADHESIOLYSIS W CC	31	31	$65,181.86	12.2	7
92	INTERSTITIAL LUNG DISEASE W CC	6	6	$83,320.67	12.2	2
79	RESP INFECTN AGE >17 W CC	1,159	1,159	$51,884.88	12.2	17
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	11	11	$50,015.40	12.1	3
146	RECTAL RESECTION W CC	21	21	$81,678.18	12.1	11
192	PANCREAS/LIVER/SHUNT PROCEDURES W/O CC	1	1	$56,012.00	12.0	1
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	38	38	$72,564.59	12.0	6
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	8	8	$17,331.75	11.9	2
236	FRACTURES OF HIP &PELVIS	51	51	$23,741.83	11.8	3
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	10	10	$63,020.81	11.5	4
226	SOFT TISSUE PROCEDURES W CC	19	19	$62,806.73	11.3	6
233	OTHR MUSKELET SYS/CONN TIS O.R. PR W CC	7	7	$54,610.58	11.1	4
269	OTHR SKIN SUBCUT TISS/BREAST PROC W CC	26	24	$47,021.07	11.0	5
151	PERITONEAL ADHESIOLYSIS W/O CC	1	1	$31,507.00	11.0	1
271	SKIN ULCERS	38	38	$29,941.79	10.8	2
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	11	11	$115,505.53	10.6	4
241	CONNECTIVE TISSUE DISORDERS W/O CC	4	4	$41,158.00	10.5	2
7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	22	22	$52,190.85	10.5	7
197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	58	58	$73,185.65	10.4	11
239	PATHOLGCL FRACT/MUSKELETL/CON TISS MALIG	1	1	$36,051.00	10.0	1
238	OSTEOMYELITIS	11	11	$54,080.88	10.0	4
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	20	20	$40,579.93	9.8	4
149	MAJOR SMALL/LARGE BOWEL PROCS W/O CC	5	5	$55,962.63	9.8	2
430	PSYCHOSES	6,930	6,927	$15,907.27	9.4	7
297	NUTRITNL/MISC METABOLIC DIS AGE>17 WO CC	93	92	$20,477.57	9.0	3
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	24	24	$118,186.98	9.0	2
240	CONNECTIVE TISSUE DISORDERS W CC	3	3	$62,432.67	9.0	1
10	NERVOUS SYSTEM NEOPLASMS W CC	2	2	$65,825.50	9.0	1
82	RESPIRATORY NEOPLASMS	58	58	$93,914.02	8.7	3
2	CRANIOTOMY AGE >17 W/O CC	3	3	$58,602.67	8.7	1
157	ANAL &STOMAL PROCEDURES W CC	5	5	$46,812.00	8.5	2
244	BONE DISEASE/SPECIFIC ARTHROPATHIES W CC	2	2	$15,838.00	8.5	1
416	SEPTICEMIA AGE >17	1,649	1,649	$41,304.54	8.2	17
172	DIGESTIVE MALIGNANCY W CC	7	7	$42,112.86	8.0	1
86	PLEURAL EFFUSION W/O CC	1	1	$33,654.00	8.0	1
273	MAJOR SKIN DISORDERS W/O CC	1	1	$21,224.00	8.0	1
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	107	107	$12,829.55	7.5	2
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	653	653	$40,018.27	7.2	9
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	4	4	$392,485.25	7.0	1
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1,010	1,010	$23,938.88	6.6	12
316	RENAL FAILURE	964	964	$25,304.73	6.4	12
130	PERIPHERAL VASCULAR DISORDERS W CC	65	65	$15,028.32	6.3	2

Exhibit F
ALOS

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
144	OTHER CIRCULATORY SYSTEM DIAG W CC	108	108	$23,767.27	6.1	3
497	SPINAL FUSION EXCEPT CERVICAL W CC	117	117	$109,513.04	6.0	6
155	STMCH/ESOPHGL/DUODNL PROC AGE >17 W/O CC	8	8	$57,604.61	6.0	3
15	NONSPEC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	85	85	$17,100.41	5.9	2
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	3,694	3,694	$24,035.14	5.8	20
188	OTHER DIGESTIVE SYSTEM DIAG AGE>17 W CC	337	337	$21,234.59	5.7	5
277	CELLULITIS AGE >17 W CC	659	659	$16,501.32	5.5	11
127	HEART FAILURE &SHOCK	4,446	4,444	$22,313.71	5.1	21
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	1,550	1,550	$18,048.94	4.9	18
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	117	117	$89,201.88	4.6	5
24	SEIZURE & HEADACHE AGE >17 W CC	196	196	$15,501.71	4.6	3
395	RED BLOOD CELL DISORDERS AGE >17	396	396	$15,213.82	4.4	9
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	1,652	1,652	$16,637.17	4.4	19
294	DIABETES AGE >35	903	903	$12,613.81	4.0	14
278	CELLULITIS AGE >17 W/O CC	87	87	$12,006.50	3.5	2
25	SEIZURE & HEADACHE AGE >17 W/O CC	87	87	$8,871.24	3.0	2

Exhibit F
Charges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
18	CRANIAL & PERIPHRL NERV DISORDERS W CC	9	9	$498,348.22	167.0	1
16	NONSPEC CEREBROVASCULAR DISORDERS W CC	28	28	$469,676.22	217.9	3
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	4	4	$392,485.25	7.0	1
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	18	18	$318,842.86	125.5	3
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	5	5	$262,905.40	32.6	1
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	35	35	$204,819.88	16.2	2
475	RESPIRATORY SYS DIAG W VENTILATOR SUPORT	1,358	1,358	$179,123.71	24.0	21
462	REHABILITATION	1,191	1,188	$174,457.05	51.3	6
108	OTHER CARDIOTHORACIC PROCEDURES	9	9	$159,093.13	15.8	2
28	TRAUMATIC STPR/COMA <1 HR AGE >17 W CC	2	2	$132,716.50	49.5	2
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	38	38	$124,204.06	41.1	5
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	24	24	$118,186.98	9.0	2
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	51	51	$116,174.51	75.6	2
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	11	11	$115,505.53	10.6	4
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	18	18	$109,781.15	15.1	2
497	SPINAL FUSION EXCEPT CERVICAL W CC	117	117	$109,513.04	6.0	6
501	KNEE PROCEDURES W PDX OF INFECTION W CC	9	9	$107,899.33	14.4	3
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	129	128	$105,061.14	22.3	15
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	186	186	$100,296.99	13.5	20
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	301	301	$99,000.36	16.1	20
126	ACUTE & SUBACUTE ENDOCARDITIS	17	17	$94,851.85	14.4	6
82	RESPIRATORY NEOPLASMS	58	58	$93,914.02	8.7	3
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	14	14	$92,417.92	12.5	7
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	14	14	$90,561.54	13.0	6
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	117	117	$89,201.88	4.6	5
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	3	3	$85,156.67	16.3	3
75	MAJOR CHEST PROCEDURES	59	59	$83,606.12	15.5	13
92	INTERSTITIAL LUNG DISEASE W CC	6	6	$83,320.67	12.2	2
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	20	20	$82,775.42	13.9	4
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	70	70	$82,501.52	13.9	9
146	RECTAL RESECTION W CC	21	21	$81,678.18	12.1	11
292	OTHR ENDOCRINE NUTRIT/METAB O.R. PROC W CC	15	15	$78,793.50	17.8	5
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	638	638	$78,005.22	12.7	21
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	13	13	$76,708.16	15.7	5
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	18	18	$76,632.37	14.6	7
218	LWR EXTRM/HUMR EX HIP,FT,FMR AGE>17 W CC	2	2	$73,195.50	20.0	1
197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	58	58	$73,185.65	10.4	11
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	237	237	$73,089.65	13.4	18
1	CRANIOTOMY AGE >17 W CC	101	101	$72,846.10	13.1	7
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	38	38	$72,564.59	12.0	6
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	114	114	$69,286.59	14.5	13
304	KIDNEY,URETR/MJR BLADDR PR NONNEOPL W CC	5	5	$67,311.33	14.2	3

Exhibit F
Charges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
502	KNEE PROCEDURES W PDX OF INFECTION WO CC	3	3	$67,193.25	23.3	2
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	32	32	$66,254.10	15.4	6
10	NERVOUS SYSTEM NEOPLASMS W CC	2	2	$65,825.50	9.0	1
150	PERITONEAL ADHESIOLYSIS W CC	31	31	$65,181.86	12.2	7
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	10	10	$63,020.81	11.5	4
226	SOFT TISSUE PROCEDURES W CC	19	19	$62,806.73	11.3	6
240	CONNECTIVE TISSUE DISORDERS W CC	3	3	$62,432.67	9.0	1
263	SKIN GRAFT DEBRID SKN ULCR/CELLITIS W CC	66	66	$60,745.83	12.7	6
2	CRANIOTOMY AGE >17 W/O CC	3	3	$58,602.67	8.7	1
155	STMCH/ESOPHGL/DUODNL PROC AGE >17 W/O CC	8	8	$57,604.61	6.0	3
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	19	19	$56,026.35	13.4	7
192	PANCREAS/LIVER/SHUNT PROCEDURES W/O CC	1	1	$56,012.00	12.0	1
149	MAJOR SMALL/LARGE BOWEL PROCS W/O CC	5	5	$55,962.63	9.8	2
85	PLEURAL EFFUSION W CC	2	2	$55,525.50	17.5	1
233	OTHR MUSKELET SYS/CONN TIS O.R. PR W CC	7	7	$54,610.58	11.1	4
238	OSTEOMYELITIS	11	11	$54,080.88	10.0	4
7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	22	22	$52,190.85	10.5	7
79	RESP INFECTN AGE >17 W CC	1,159	1,159	$51,884.88	12.2	17
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	11	11	$50,015.40	12.1	3
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	5	5	$48,686.00	17.0	5
269	OTHR SKIN SUBCUT TISS/BREAST PROC W CC	26	24	$47,021.07	11.0	5
157	ANAL &STOMAL PROCEDURES W CC	5	5	$46,812.00	8.5	2
78	PULMONARY EMBOLISM	10	10	$42,677.38	12.8	4
172	DIGESTIVE MALIGNANCY W CC	7	7	$42,112.86	8.0	1
416	SEPTICEMIA AGE >17	1,649	1,649	$41,304.54	8.2	17
241	CONNECTIVE TISSUE DISORDERS W/O CC	4	4	$41,158.00	10.5	2
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	20	20	$40,579.93	9.8	4
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	653	653	$40,018.27	7.2	9
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	8	8	$39,774.17	13.1	6
239	PATHOLGCL FRACT/MUSKELETL/CON TISS MALIG	1	1	$36,051.00	10.0	1
86	PLEURAL EFFUSION W/O CC	1	1	$33,654.00	8.0	1
256	OTHR MUSKELETAL SYSTM/CONN TISS DIAG	1	1	$31,658.00	13.0	1
151	PERITONEAL ADHESIOLYSIS W/O CC	1	1	$31,507.00	11.0	1
271	SKIN ULCERS	38	38	$29,941.79	10.8	2
316	RENAL FAILURE	964	964	$25,304.73	6.4	12
145	OTHER CIRCULATORY SYSTEM DIAG W/O CC	1	1	$24,430.00	13.0	1
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	3,694	3,694	$24,035.14	5.8	20
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1,010	1,010	$23,938.88	6.6	12
144	OTHER CIRCULATORY SYSTEM DIAG W CC	108	108	$23,767.27	6.1	3
236	FRACTURES OF HIP &PELVIS	51	51	$23,741.83	11.8	3
127	HEART FAILURE &SHOCK	4,446	4,444	$22,313.71	5.1	21
188	OTHER DIGESTIVE SYSTEM DIAG AGE>17 W CC	337	337	$21,234.59	5.7	5
273	MAJOR SKIN DISORDERS W/O CC	1	1	$21,224.00	8.0	1

Exhibit F
Charges

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
297	NUTRITNL/MISC METABOLIC DIS AGE>17 WO CC	93	92	$20,477.57	9.0	3
189	OTHER DIGESTIVE SYSTM DIAG AGE>17 W/O CC	14	14	$18,539.14	80.5	1
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	1,550	1,550	$18,048.94	4.9	18
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	8	8	$17,331.75	11.9	2
15	NONSPEC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	85	85	$17,100.41	5.9	2
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	1,652	1,652	$16,637.17	4.4	19
277	CELLULITIS AGE >17 W CC	659	659	$16,501.32	5.5	11
430	PSYCHOSES	6,930	6,927	$15,907.27	9.4	7
244	BONE DISEASE/SPECIFIC ARTHROPATHIES W CC	2	2	$15,838.00	8.5	1
24	SEIZURE & HEADACHE AGE >17 W CC	196	196	$15,501.71	4.6	3
395	RED BLOOD CELL DISORDERS AGE >17	396	396	$15,213.82	4.4	9
130	PERIPHERAL VASCULAR DISORDERS W CC	65	65	$15,028.32	6.3	2
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	107	107	$12,829.55	7.5	2
294	DIABETES AGE >35	903	903	$12,613.81	4.0	14
278	CELLULITIS AGE >17 W/O CC	87	87	$12,006.50	3.5	2
25	SEIZURE & HEADACHE AGE >17 W/O CC	87	87	$8,871.24	3.0	2

Exhibit F
Frequency

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
475	RESPIRATORY SYS DIAG W VENTILATOR SUPORT	1,358	1,358	$179,123.71	24.0	21
148	MAJOR SMALL/LARGE BOWEL PROCEDURES W CC	638	638	$78,005.22	12.7	21
127	HEART FAILURE &SHOCK	4,446	4,444	$22,313.71	5.1	21
154	STMCH/ESOPHGL/DUODNL PROCS AGE >17 W CC	186	186	$100,296.99	13.5	20
415	O.R. PROC INFECTIOUS/PARASITIC DISEASES	301	301	$99,000.36	16.1	20
89	SIMPLE PNEUMONIA/PLEURISY AGE >17 W CC	3,694	3,694	$24,035.14	5.8	20
296	NUTRITONL/MISC METABOLIC DIS AGE>17 W CC	1,652	1,652	$16,637.17	4.4	19
468	EXTENSIVE O.R. PROC UNRELATED PRIN DIAG	237	237	$73,089.65	13.4	18
320	KIDNEY/URINARY TRACT INFECT AGE>17 W CC	1,550	1,550	$18,048.94	4.9	18
79	RESP INFECTN AGE >17 W CC	1,159	1,159	$51,884.88	12.2	17
416	SEPTICEMIA AGE >17	1,649	1,649	$41,304.54	8.2	17
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	129	128	$105,061.14	22.3	15
294	DIABETES AGE >35	903	903	$12,613.81	4.0	14
75	MAJOR CHEST PROCEDURES	59	59	$83,606.12	15.5	13
113	AMP FOR CIRC SYST DISOR EXC UPR LIMB/TOE	114	114	$69,286.59	14.5	13
316	RENAL FAILURE	964	964	$25,304.73	6.4	12
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1,010	1,010	$23,938.88	6.6	12
146	RECTAL RESECTION W CC	21	21	$81,678.18	12.1	11
197	CHOLECYSTCTMY EX LAPRSCOPE W/O CDE W C C	58	58	$73,185.65	10.4	11
277	CELLULITIS AGE >17 W CC	659	659	$16,501.32	5.5	11
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	70	70	$82,501.52	13.9	9
121	CIRC DISORD W AMI/MAJOR COMP DISCH ALIVE	653	653	$40,018.27	7.2	9
395	RED BLOOD CELL DISORDERS AGE >17	396	396	$15,213.82	4.4	9
191	PANCREAS/LIVER/SHUNT PROCEDURES W CC	14	14	$92,417.92	12.5	7
213	AMPUTATN MUSCSKELETL SYS/CONN TISSUE DIS	18	18	$76,632.37	14.6	7
1	CRANIOTOMY AGE >17 W CC	101	101	$72,846.10	13.1	7
150	PERITONEAL ADHESIOLYSIS W CC	31	31	$65,181.86	12.2	7
170	OTHER DIGESTIVE SYSTEM O.R. PROCS W CC	19	19	$56,026.35	13.4	7
7	PERIPH/CRANL NERVE/OTHER NERV PROC W CC	22	22	$52,190.85	10.5	7
430	PSYCHOSES	6,930	6,927	$15,907.27	9.4	7
462	REHABILITATION	1,191	1,188	$174,457.05	51.3	6
497	SPINAL FUSION EXCEPT CERVICAL W CC	117	117	$109,513.04	6.0	6
126	ACUTE & SUBACUTE ENDOCARDITIS	17	17	$94,851.85	14.4	6
423	OTHER INFECTIOUS/PARASITIC DISEASE DIAG	14	14	$90,561.54	13.0	6
210	HIP/FEMUR PROC EX MJR JOINT AGE>17 W CC	38	38	$72,564.59	12.0	6
217	WND DEBRID/GRFT EX HAND MUSKELET/CON TIS	32	32	$66,254.10	15.4	6
226	SOFT TISSUE PROCEDURES W CC	19	19	$62,806.73	11.3	6
263	SKIN GRAFT DEBRID SKN ULCR/CELLITIS W CC	66	66	$60,745.83	12.7	6
216	BIOPSIES MUSCSKELETAL SYS/CONN TISSUE	8	8	$39,774.17	13.1	6
477	NON-EXTEN O.R. PROC UNRELATED PRINC DIAG	38	38	$124,204.06	41.1	5
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	117	117	$89,201.88	4.6	5
292	OTHR ENDOCRINE NUTRIT/METAB O.R. PROC W CC	15	15	$78,793.50	17.8	5

Exhibit F
Frequency

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
401	LYMPH/NONACUT LEUK W OTHR O.R. PROC W CC	13	13	$76,708.16	15.7	5
80	RESP INFECTN/INFLAMMATNS AGE >17 W/O CC	5	5	$48,686.00	17.0	5
269	OTHR SKIN SUBCUT TISS/BREAST PROC W CC	26	24	$47,021.07	11.0	5
188	OTHER DIGESTIVE SYSTEM DIAG AGE>17 W CC	337	337	$21,234.59	5.7	5
471	BILATERAL/MULT MJR JNT PROC LOWR EXTEMTY	11	11	$115,505.53	10.6	4
20	NERV SYST INFECT EXCEPT VIRAL MENINGITIS	20	20	$82,775.42	13.9	4
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	10	10	$63,020.81	11.5	4
233	OTHR MUSKELET SYS/CONN TIS O.R. PR W CC	7	7	$54,610.58	11.1	4
238	OSTEOMYELITIS	11	11	$54,080.88	10.0	4
78	PULMONARY EMBOLISM	10	10	$42,677.38	12.8	4
403	LYMPHOMA/NON-ACUTE LEUKEMIA W CC	20	20	$40,579.93	9.8	4
16	NONSPEC CEREBROVASCULAR DISORDERS W CC	28	28	$469,676.22	217.9	3
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	18	18	$318,842.86	125.5	3
501	KNEE PROCEDURES W PDX OF INFECTION W CC	9	9	$107,899.33	14.4	3
82	RESPIRATORY NEOPLASMS	58	58	$93,914.02	8.7	3
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAG	3	3	$85,156.67	16.3	3
304	KIDNEY,URETR/MJR BLADDR PR NONNEOPL W CC	5	5	$67,311.33	14.2	3
155	STMCH/ESOPHGL/DUODNL PROC AGE >17 W/O CC	8	8	$57,604.61	6.0	3
114	UPPER LIMB/TOE AMP FOR CIRC SYS DISORDER	11	11	$50,015.40	12.1	3
144	OTHER CIRCULATORY SYSTEM DIAG W CC	108	108	$23,767.27	6.1	3
236	FRACTURES OF HIP &PELVIS	51	51	$23,741.83	11.8	3
297	NUTRITNL/MISC METABOLIC DIS AGE>17 WO CC	93	92	$20,477.57	9.0	3
24	SEIZURE & HEADACHE AGE >17 W CC	196	196	$15,501.71	4.6	3
104	CARD VLV/OTR CARDITHOR O.R. W CARD CATH	35	35	$204,819.88	16.2	2
108	OTHER CARDIOTHORACIC PROCEDURES	9	9	$159,093.13	15.8	2
28	TRAUMATIC STPR/COMA <1 HR AGE >17 W CC	2	2	$132,716.50	49.5	2
105	CARD VLV/OTR CARDITHOR O.R. W/O CAR CATH	24	24	$118,186.98	9.0	2
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	51	51	$116,174.51	75.6	2
485	LIMB REATTACH/HIP/FEMUR PROC MULT TRAUMA	18	18	$109,781.15	15.1	2
92	INTERSTITIAL LUNG DISEASE W CC	6	6	$83,320.67	12.2	2
502	KNEE PROCEDURES W PDX OF INFECTION WO CC	3	3	$67,193.25	23.3	2
149	MAJOR SMALL/LARGE BOWEL PROCS W/O CC	5	5	$55,962.63	9.8	2
157	ANAL &STOMAL PROCEDURES W CC	5	5	$46,812.00	8.5	2
241	CONNECTIVE TISSUE DISORDERS W/O CC	4	4	$41,158.00	10.5	2
271	SKIN ULCERS	38	38	$29,941.79	10.8	2
429	ORGANIC DISTURBANCES/MENTAL RETARDATION	8	8	$17,331.75	11.9	2
15	NONSPEC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	85	85	$17,100.41	5.9	2
130	PERIPHERAL VASCULAR DISORDERS W CC	65	65	$15,028.32	6.3	2
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	107	107	$12,829.55	7.5	2
278	CELLULITIS AGE >17 W/O CC	87	87	$12,006.50	3.5	2
25	SEIZURE & HEADACHE AGE >17 W/O CC	87	87	$8,871.24	3.0	2
18	CRANIAL & PERIPHRL NERV DISORDERS W CC	9	9	$498,348.22	167.0	1
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	4	4	$392,485.25	7.0	1

Exhibit F
Frequency

DRG Code	DRG Description	Discharges	Valid Charges	Avg. Chg. Per Stay	ALOS	# of Hospitals
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	5	5	$262,905.40	32.6	1
218	LWR EXTRM/HUMR EX HIP,FT,FMR AGE>17 W CC	2	2	$73,195.50	20.0	1
10	NERVOUS SYSTEM NEOPLASMS W CC	2	2	$65,825.50	9.0	1
240	CONNECTIVE TISSUE DISORDERS W CC	3	3	$62,432.67	9.0	1
2	CRANIOTOMY AGE >17 W/O CC	3	3	$58,602.67	8.7	1
192	PANCREAS/LIVER/SHUNT PROCEDURES W/O CC	1	1	$56,012.00	12.0	1
85	PLEURAL EFFUSION W CC	2	2	$55,525.50	17.5	1
172	DIGESTIVE MALIGNANCY W CC	7	7	$42,112.86	8.0	1
239	PATHOLGCL FRACT/MUSKELETL/CON TISS MALIG	1	1	$36,051.00	10.0	1
86	PLEURAL EFFUSION W/O CC	1	1	$33,654.00	8.0	1
256	OTHR MUSKELETAL SYSTM/CONN TISS DIAG	1	1	$31,658.00	13.0	1
151	PERITONEAL ADHESIOLYSIS W/O CC	1	1	$31,507.00	11.0	1
145	OTHER CIRCULATORY SYSTEM DIAG W/O CC	1	1	$24,430.00	13.0	1
273	MAJOR SKIN DISORDERS W/O CC	1	1	$21,224.00	8.0	1
189	OTHER DIGESTIVE SYSTM DIAG AGE>17 W/O CC	14	14	$18,539.14	80.5	1
244	BONE DISEASE/SPECIFIC ARTHROPATHIES W CC	2	2	$15,838.00	8.5	1