ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM HOSPITAL EMERGENCY ROOM UTILIZATION PER 1000 MM CONTRACT YEAR XX-XX

BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLE	S (With Medicare)	HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			11101 201
EMERGENCY ROOM VISITS RESULTING IN INPATIENT ADMISSION					
# of ER_VISITS	XXXX	XXXX	XXXX		XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	****
ER VISITS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
MATERNITY VISITS	XXXX	XXXX	XXXX	XXXX	XXXX
ADMISSION # of ER VISITS MEMBER MONTHS ER VISITS PER 1000 MM MATERNITY VISITS	XXXX XXXXXXXX XXX XXX	XXXX XXXXXXXX XXX XXX	XXXX XXXXXXXX XXX XXX	XXXX XXXXXXXX XXX XXX	XXXX XXXXXXXXX XXX XXX
TOTAL ER VISITS					
# of ER VISITS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ER VISITS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
MATERNITY VISITS	XXXX	XXXX	XXXX	XXXX	XXXX

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM SERVICE UTILIZATION CONTRACT YEAR XX-XX BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES PART A	S (With Medicare) OTHER	HIFA I	HIFA PARENT	PROP204
Total Member Months	XXXXX	XXXXX	ххххх	XXXXX	ххххх
# Of Unduplicated Members Enrolled in the Health Plan	ххххх	ххххх	ххххх	XXXXX	ххххх
% of Members Who Received Services	ххх	ххх	ХХХ	ХХХ	ххх
# of Services PM/PM	хххх	хххх	хххх	хххх	хххх

NOTES: 1) Title XIX, HIFA I and HIFA Parents are included in the Acute Non-KidsCare population.

BENEFICIARY GROUPS

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM INPATIENT HOSPITAL / CLINICS MATERNITY SERVICES UTILIZATION CONTRACT YEAR XX-XX **BENEFICIARY GROUPS**

XXXXXX Health Plan Name

	DUAL ELIGIBLES	S (With Medicare)	HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
DELIVERY ADMISSION					
# of DELIVERIES	XXXX	XXXX	XXXX	XXXX	XXXX
# of DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DELIVERIES per 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER DEL	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER DEL	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER DEL	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
NON HOSPITAL DEL	ХХХ	ХХХ	ХХХ	ххх	XXX
VAGINAL DELIVERY					
# of DELIVERIES	XXXX	XXXX	XXXX	XXXX	XXXX
# of DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DELIVERIES per 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER DEL	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER DEL	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER DEL	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
CESAREAN SECTION					
# of DELIVERIES	XXXX	XXXX	XXXX	XXXX	XXXX
# of DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DELIVERIES per 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER DEL	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER DEL	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER DEL	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.
2) These beneficiary groups do not represent 100% of Acute Care members thus numbers will not tie to other UR reports.
3) Non-hospital Delivery includes deliveries in free-standing birthing centers (Provider type 83).

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM TRANSPORTATION SERVICES UTILIZATION CONTRACT YEAR XX-XX **BENEFICIARY GROUPS**

BENEFICIARY GROUPS

XXXXXX Health Plan Name

		S (With Medicare)	HIFA I	HIFA PARENT	PROP204
EMERGENCY TRANSPORTATION PROVIDERS	PART A	OTHER			
EMERGENCY TRANSPORTATION PROVIDERS					
# of TRIPS		V/V/V	V/V/V/		10000
# 01 TRIPS MEMBER MONTHS	XXXX XXXXXXXX	XXXX XXXXXXXX	XXXX XXXXXXXX	XXXX XXXXXXXX	XXXX XXXXXXXX
# of SERVICES PER 1000 MM	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXX XXX	XXXXXXXX XXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
AVG HEALTH PLAN PMT PER SVC					
	\$\$\$\$.00 \$\$\$\$\$.00	\$\$\$\$.00 \$\$\$\$\$	\$\$\$\$.00 \$\$\$\$\$	\$\$\$\$.00 \$\$\$\$\$	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC AVG BILLED CHARGES PER SVC	\$\$\$\$.00 \$\$\$\$.00	\$\$\$\$.00 \$\$\$\$\$.00	\$\$\$\$.00 \$\$\$\$\$.00	\$\$\$\$.00 \$\$\$\$.00	\$\$\$\$.00 \$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
EMERGENCY: GROUND TRANSPORTATION					
# of TRIPS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
TOTAL EMERGENCY SERVICES					
# of TRIPS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
TOTAL NON-EMERGENCY SERVICES					
# of TRIPS	XXXX	XXXX	XXXX	XXXX	XXXX
# OF TRES MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	ХХХ	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG ALCCCS ALLOWED AMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00
AVG AILCCCS ALLOWED AMIT FER SVC	\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00
AVO DIELED CHARGEST ER SVC	ΦΦΦΦΦ.00	\$\$\$\$.00	φφφφ.00	φφφφ.00	\$\$\$\$
EMERGENCY TRANSPORTATION PROVIDER TOTAL					
# of TRIPS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM TRANSPORTATION SERVICES UTILIZATION CONTRACT YEAR XX-XX **BENEFICIARY GROUPS**

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLE PART A	S (With Medicare) OTHER	HIFA I	HIFA PARENT	PROP204
	PARTA	UTHER			
NON-EMERGENCY TRANSPORTATION PROVIDERS					
TAXI SERVICES					
# of TRIPS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
BUS SERVICES					
# of TRIPS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG ALCCCS ALLOWED AMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG DILLED CHARGES PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
VAN SERVICES					
# of TRIPS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AIR TAXI SERVICES					
# of TRIPS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	ХХХ	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00
AND DIELED CHARGEST ER SVC	ψψψψψ.00	ψψψψψ.00	ψψψψψ.00	ψψψψψ.00	ψψψψ.00
NON-EMERGENCY TRANSPORTATION PROVIDER TO	DTAL				
# of TRIPS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.

2) These beneficiary groups do not represent 100% of Acute Care members thus numbers will not tie to other UR reports.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM DENTAL SERVICES UTILIZATION CONTRACT YEAR XX-XX BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
PREVENTATIVE SERVICES					
# of SERVICES	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
TREATMENT					
# of SERVICES	XXXX	XXXXXXXX	XXXXXXXX	xxxxxxx	XXXXXXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
TOTAL DENTAL SERVICES					
# OF SERVICES	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLE	S (With Medicare)	HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
ICU / ROUTINE					
Excluding Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00
TOTAL ICU/ROUTINE					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	xxxxxxxx
# OF TIER DAYS	XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX XXXX	XXXXXXXXXX	XXXXX XXXX
# OF THER DATS MEMBER MONTHS	XXXX XXXXXXXX	XXXX XXXXXXXX		XXXX XXXXXXXX	×××× ××××××××
ALOS			XXXXXXXX		
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
# OF DAYS PER 1000 MM AVG HEALTH PLAN PMT PER ADMIT	XXX ¢¢¢¢¢¢	XXX ¢¢¢¢¢¢	XXX ¢¢¢¢¢¢	XXX ¢¢¢¢¢¢	XXX
AVG HEALTH PLAN PMT PER ADMIT AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00 \$\$\$\$\$	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00 \$\$\$\$\$	\$\$\$\$\$\$.00
	\$\$\$\$\$.00 ******	\$\$\$\$\$.00 \$\$\$\$\$	\$\$\$\$\$.00 \$\$\$\$\$	\$\$\$\$\$.00 \$\$\$\$\$	\$\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES	S (With Medicare)	HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
ICU / PSYCHIATRIC					
Excluding Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	ХХХ
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
TOTAL ICU/PSYCHIATRIC					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLE	S (With Medicare)	HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
ICU / SURGERY					
Excluding Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	*****	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXXX		XXXX	XXXXX
MEMBER MONTHS	XXXXX	XXXXXXXXX		XXXXXXXXX	XXXXXXXX
ALOS	XXX	XXX		XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
	ψψψψψ.00	<i>\</i>	ψψψψψ.00	44444.00	ψψψψψ.00
Qualified Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLE	S (With Medicare)	HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
NICU / NURSERY					
Excluding Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	ХХХХ	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX XXX	XXX	XXX	XXX XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.UU	\$\$\$\$\$.00	\$\$\$\$ \$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	xxxxxxx	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
TOTAL NICU/NURSERY					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLE	S (With Medicare)	HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
ROUTINE					
Excluding Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXXX	XXXXXXXXX
ALOS	XXX	XXX	XXX	XXX	ХХХ
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLE	S (With Medicare)	HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
NURSERY					
Excluding Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	ХХХ	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG HEALTH FLAN FINT FER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG ANCCOS ALLOWED AWIT PER ADWIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG DILLED CHARGES PER ADIVIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	xxxxxxx	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	xxxxxxx	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
TOTAL NURSERY					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
PSYCHIATRIC					
Excluding Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS					
ALOS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX ¢¢¢¢¢¢	XXX ¢¢¢¢¢¢ QQ	XXX ¢¢¢¢¢¢	XXX ¢¢¢¢¢¢	XXX ¢¢¢¢¢¢¢
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AILCOUS ALLOWED AMILE ADMIL	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
	ΨΨΨΨΨΦ	ψψψψψ 0 Ο	ψψψψψψ.00	44444.00	ψψψψψψ.00
TOTAL PSYCHIATRIC					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
SURGERY					
Excluding Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
TOTAL SURGERY					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
ICU					
Excluding Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00
TOTALICU					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXXXXXX XXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXX XXXX
# OF HER DATS MEMBER MONTHS					
ALOS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX ####### OO	XXX	XXX ¢¢¢¢¢¢	XXX ¢¢¢¢¢¢	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00 \$\$\$\$\$	\$\$\$\$\$.00 ******	\$\$\$\$\$.00 \$\$\$\$\$	\$\$\$\$\$.00 \$\$\$\$\$	\$\$\$\$\$.00 \$\$\$\$\$
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00 ******	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
NICU					
Excluding Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	ХХХ	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT		\$\$\$\$\$.00	\$\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$\$.00
	\$\$\$\$\$.00				
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	xxxxxxx	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	xxxx	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
	44444.00	*****	44444.00	+++++.00	\$\$\$
TOTAL NICU					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	xxxxxxx	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

BENEFICIARY GROUPS

XXXXXX Health Plan Name

ARIZONA REALTH CARE COST CONTAINMENT STSTEM
INPATIENT HOSPITAL STATISTICS by TIER
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
MATERNITY					
Excluding Outlier Totals for the Tier	2000				
# of ADMITS # OF TIER DAYS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM					
	XXX	XXX ¢¢¢¢¢¢ QQ	XXX ¢¢¢¢¢¢	XXX ¢¢¢¢¢¢	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
TOTAL MATERNITY					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	xxxxxxx	XXXXXXXX
# OF TIER DAYS	XXXX	XXXX	XXXX	XXXX	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVO DILLED GHARGES PER ADIVIT	ንንንንንን.UU	ንንንንንን UU	\$\$\$\$\$.UU	ንንንንንን UU	ንንንንንንን UU

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM OUTPATIENT HOSPITAL VISITS PER 1000 MM CONTRACT YEAR XX-XX **BENEFICIARY GROUPS**

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
I. OUTPATIENT VISITS RESULTING IN INPATIENT ADMISSION					
# of ADMITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# OF DAYS	XXXX	XXXX	XXXX	ХХХХ	XXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
ALOS	XXX	XXX	XXX	XXX	XXX
# of DAYS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER ADMIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
II. OUTPATIENT VISITS: NO INPATIENT					
ADMISSION					
EMERGENCY ROOM VISITS					
# of VISITS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of VISITS PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER VISIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER VISIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER VISIT	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
CLINIC SERVICES					
# OF SERVICES	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
SURGERY # of SURGERIES	VVV	VVVVVVV	~~~~~	~~~~~	VVVVVVV
# 0F SURGERIES MEMBER MONTHS	XXXX XXXXXXXX	XXXXXXXX XXXXXXXX	XXXXXXXX XXXXXXXX	XXXXXXXX XXXXXXXX	XXXXXXXX XXXXXXXX
# of SERVICES PER 1000 MM	XXXXXXXX XXX	XXXXXXXX XXX	XXXXXXXX XXX	XXXXXXXX XXX	XXXXXXXX XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$\$.00	xxx \$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
	<i>ψψψψψ</i> .00	44444.00	44444.00	44444.00	44444.00

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM OUTPATIENT HOSPITAL VISITS PER 1000 MM CONTRACT YEAR XX-XX **BENEFICIARY GROUPS**

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLE: PART A	S (With Medicare) OTHER	HIFA I	HIFA PARENT	PROP204
OBSERVATION SERVICES					
# OF SERVICES	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
RADIOLOGY SERVICES					
# OF SERVICES	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00
LABORATORY SERVICES					
# OF LAB TESTS	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$.00	\$\$\$\$\$.00
THERAPEUTIC SERVICES					
# OF SERVICES	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXXX	XXXXXXXX	XXXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
DIAGNOSTIC SERVICES					
# Of SERVICES	XXXX	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM OUTPATIENT HOSPITAL VISITS PER 1000 MM CONTRACT YEAR XX-XX BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLE	S (With Medicare)	HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
ALL OTHER SERVICES					
# Of SERVICES	XXXX	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	xxxxxxx	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
TOTAL OUTPATIENT VISITS: NO INPATIENT ADMIS	SION				
# OF SERVICES	XXXX	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
III. TOTAL OUTPATIENT VISITS					
# OF SERVICES	XXXX	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
MEMBER MONTHS	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
# of SERVICES PER 1000 MM	XXX	XXX	XXX	XXX	XXX
AVG HEALTH PLAN PMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG AHCCCS ALLOWED AMT PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00
AVG BILLED CHARGES PER SVC	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00	\$\$\$\$\$.00

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.

2) These beneficiary groups do not represent 100% of Acute Care members thus numbers will not tie to other UR reports.