

EXHIBIT “L”
to Third Amended Complaint

U.S. ex rel. Williams v. Health Management Associates, Inc., Tenet Healthcare Corporation and Hispanic Medical Management d/b/a Clinica de la Mama, et al.

POWER OF ATTORNEY FOR ELECTRONIC CLAIMS SUBMISSION

KNOW ALL MEN BY THESE PRESENTS, THAT:

Provider, Spalding Regional Medical Center (Provider's Name), with Provider Number(s)

hereby appoints Emdeon (Name of Billing Service), 103626 (Billing Service Trading Partner ID) as attorney-in-fact for the benefit of Provider, and in Provider's name, place and stead for the following purposes:

To act as billing service for Provider in submitting Provider's medical assistance claims by Computer Media Input to the Department of Community Health, Division of Medical Assistance (the "Department"), for reimbursement of Provider under the Title XIX ("Medicaid") program in Georgia;

To act as Provider's authorized agent for purposes of signing, on behalf of Provider, the certification statement herein in connection with each Computer Media Input submission of medical assistance claims:

"I hereby certify that all information contained on and submitted by Computer Media Input is true, accurate, and complete, and that to the best of my knowledge, information and belief, the services for which medical assistance was sought, in fact, have been rendered by Provider as claimed. Furthermore, I understand and acknowledge that the Department will rely on this certification in the payment of medical assistance, which payment will be made from State and Federal funds, and that the submission of any false claims, information, or documents or the concealment of any material facts is a crime under Federal and State laws."

To maintain all original source documents for six (6) years following the month of payment, and to ensure that every electronic entry can be associated and identified with a source document.

Provider agrees that the billing service is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable.

Provider understands that the granting of this Power of Attorney in no way limits or discharges the ultimate responsibility and liability of Provider for the truthfulness, completeness and accuracy of any and all medical assistance claims submitted by the appointed billing service, and in no way forecloses the application of penalties that may be accessed under the False Claims Act and other applicable federal and state laws.

IN WITNESS WHEREOF, Provider has affixed Provider's seal by the hand of one authorized to act on Provider's behalf.

This 23rd day of June, in the year 2009.

Spalding Regional Medical Center
Printed Name of Enrolled Provider

By: [Signature]
Signature of Provider or Authorized Representative

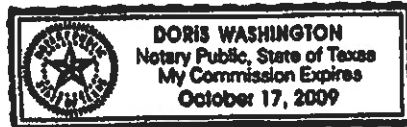
Manager, Payer Services
Title of Authorized Representative

ORIGINAL

Sworn to and subscribed before me this 23rd day of June, in the year 2009.

[Signature]
(Notary Public)

My Commission expires: October 17, 2009



829070800591

POWER OF ATTORNEY FOR ELECTRONIC CLAIMS SUBMISSION

KNOW ALL MEN BY THESE PRESENTS, THAT:

Provider, SYLVAN GROVE HOSPITAL (Provider's Name), with Provider Number(s)

hereby appoints Emdeon

(Name of Billing Service), 103626 (Billing Service Trading Partner ID) as attorney-in-fact

for the benefit of Provider, and in Provider's name, place and stead for the following purposes:

To act as billing service for Provider in submitting Provider's medical assistance claims by Computer Media Input to the Department of Community Health, Division of Medical Assistance (the "Department"), for reimbursement of Provider under the Title XIX ("Medicaid") program in Georgia;

To act as Provider's authorized agent for purposes of signing, on behalf of Provider, the certification statement herein in connection with each Computer Media Input submission of medical assistance claims:

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Provider understands that the granting of this Power of Attorney in no way limits or discharges the ultimate responsibility and liability of Provider for the truthfulness, completeness and accuracy of any and all medical assistance claims submitted by the appointed billing service, and in no way forecloses the application of penalties that may be accessed under the False Claims Act and other applicable federal and state laws.

IN WITNESS WHEREOF, Provider has affixed Provider's seal by the hand of one authorized to act on Provider's behalf.

This 3rd day of June, in the year 2009.

SYLVAN GROVE HOSPITAL

Printed Name of Enrolled Provider

By:

Signature of Provider or Authorized Representative

Manager Payer Services

Title of Authorized Representative

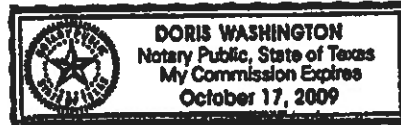
ORIGINAL

Sworn to and subscribed before me this 3rd day of June, in the year 2009.

(Notary Public)

My Commission expires:

October 17, 2009



819061601254

POWER OF ATTORNEY FOR ELECTRONIC CLAIMS SUBMISSION

KNOW ALL MEN BY THESE PRESENTS, THAT:

Provider, Atlanta Medical Center (Provider's Name), with Provider Number(s)

1 [Redacted] hereby appoints NDCHhealth
(Name of Billing Service), 10222 (Billing Service Trading Partner ID) as attorney-in-fact

for the benefit of Provider, and in Provider's name, place and stead for the following purposes:

To act as billing service for Provider in submitting Provider's medical assistance claims by Computer Media Input to the Department of Community Health, Division of Medical Assistance (the "Department"), for reimbursement of Provider under the Title XIX ("Medicaid") program in Georgia;

To act as Provider's authorized agent for purposes of signing, on behalf of Provider, the certification statement herein in connection with each Computer Media Input submission of medical assistance claims:

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IN WITNESS WHEREOF, Provider has affixed Provider's seal by the hand of one authorized to act on Provider's behalf.

This 23rd day of June, in the year 2005.

Atlanta Medical Center

Printed Name of Enrolled Provider

By: [Signature]

Signature of Provider or Authorized Representative

Manager, Corporate Information Systems

Title of Authorized Representative

Sworn to and subscribed before me
this 23 day of June, in the year 2005.

[Signature]
(Notary Public)

My Commission expires: 4/27/09

81511402255

POWER OF ATTORNEY FOR ELECTRONIC CLAIMS SUBMISSION

KNOW ALL MEN BY THESE PRESENTS, THAT:

Provider, ATLANTA MEDICAL CENTER (Provider's Name), with Provider Number(s)

hereby appoints Emdeon

(Name of Billing Service), 103626 (Billing Service Trading Partner ID) as attorney-in-fact

for the benefit of Provider, and in Provider's name, place and stead for the following purposes:

To act as billing service for Provider in submitting Provider's medical assistance claims by Computer Media Input to the Department of Community Health, Division of Medical Assistance (the "Department"), for reimbursement of Provider under the Title XIX ("Medicaid") program in Georgia;

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IN WITNESS WHEREOF, Provider has affixed Provider's seal by the hand of one authorized to act on Provider's behalf.

This 3rd day of June, in the year 2009.

ATLANTA MEDICAL CENTER

Printed Name of Enrolled Provider

By: [Signature] Signature of Provider or Authorized Representative

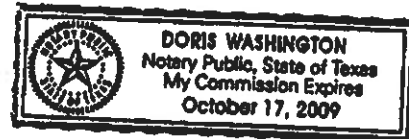
Manager, Payer Services Title of Authorized Representative

ORIGINAL

Sworn to and subscribed before me this 3rd day of June, in the year 2009.

[Signature] (Notary Public)

My Commission expires: October 17, 2009



819061601253